ALLERGY/DIETARY RESTRICTION STATEMENT

Please indicate if your child has any known allergies or dietary restrictions by completing this form and returning it to the Health Office. Please describe your child's allergic reaction and any medications used to treat this reaction, if applicable. Thank you.

____ _____________________________________

Child's Name Classroom Name

_______ NO KNOWN ALLERGIES

- Food Allergy: (e.g. peanuts, strawberries, etc.)
  - Food: ________________________________
  - Reaction: _____________________________
  - Date of Blood Test Confirmation: ________
  - Treatment: ____________________________
  - Date of Doctor's Documentation: ________
- Medication Allergy: (e.g. Augmentin, Penicillin, etc.)
  - Medicine: _____________________________
  - Reaction: _____________________________
  - Treatment: ____________________________
- Other Allergy: (e.g. bees, dust, mold, etc.)
  - Allergen: _____________________________
  - Reaction: _____________________________
  - Medication: ___________________________
- Food Restriction:
  - Personal: _____________________________
    - Reason: ______________________
      - (please describe) _________ ________________________
    - Religious: ______________________
    - Family Allergy History: ___________

_______________________________________ _____________________________________

Name of Parent/Guardian (print) Signature of Parent/Guardian

Date: ________________________