ALLERGY INFORMATION

Name:	
DOB:	
Address:	

Title	Name	Home Phone	Cell phone	Work Phone
Contact 1				
Contact 2				
Emergency Contact 1				
Emergency Contact 2				

Please fill out the following information about your participants allergies:

Identify allergens (check all that apply to participant)	
☐ Insect bite/sting _____	☐ Dust
☐ Mold	☐ Animal: _____
☐ Pollen: _____	☐ Strong odor or fume: _____
☐ Perfume/Cologne/Aftershave	☐ Foods: _____
☐ Carpet	☐ Chalk dust
☐ Other: _____	☐ Latex

Please describe reaction:

Reaction:	
☐ Hives and itchiness (where?) _____	☐ Swelling (where?) _____
☐ Nausea, vomiting, diarrhea	☐ Coughing, wheezing or change of voice
☐ Difficulty breathing or swallowing	☐ Fainting or loss of consciousness
☐ Panic or sense of doom	☐ Other (please specify) _____
☐ Throat tightness or closing	

ALLERGY INFORMATION

Medication:

Please list **medications** prescribed for allergies only (including dosage and frequency)	

Uses Epi Pen: ☐ YES ☐ NO Epi Pen is carried by: _____

Special Instructions:

Please provide any special instructions for staff to follow before, during and after an allergic reaction	

_____ _____ _____

Name of parent/guardian Signature of parent/guardian Date