



## Child Allergy and Health History Form

Name of Child \_\_\_\_\_, \_\_\_\_\_  
Last Name First Name

**ALLERGIES** - What is your child's allergy (Food, Medical, Drugs, Stings, etc.)? What is the reaction? Explain in detail:

\_\_\_\_\_  
\_\_\_\_\_

Is your child taking any regular allergy injections?

\_\_\_\_\_  
\_\_\_\_\_

How should the staff respond to your child's allergy situation, should it arise?

\_\_\_\_\_  
\_\_\_\_\_

**FOOD ALLERGIES** – What food substitutes can be served to your child?

\_\_\_\_\_  
\_\_\_\_\_

### **Does your child have:**

1. Any special requirements for diet, rest, exercise?

\_\_\_\_\_  
\_\_\_\_\_

2. History of communicable disease including any other health problems?

\_\_\_\_\_  
\_\_\_\_\_

3. Is your child taking any regular medication?

\_\_\_\_\_  
\_\_\_\_\_

4. Is there any other medical condition about your child that the School should be aware of so that staff can deal with it appropriate?

\_\_\_\_\_  
\_\_\_\_\_