STUDENT ALLERGY FORM

Child's Full Name:	Today's Date:
Food the child must not consume (list each food separately)	Appropriate substitute food(s)
Describe allergic reactions and symptoms associated with this child's particular allergies.	
Describe the treatment plan for the early learning or school-age provider to follow in response to child's allergic reaction (include names of medication, dosage amount, and directions for how to administer medication).	
Other special dietary requirements due to a health condition.	

☐ **Check box if allergy is life threatening**

If allergy is life threatening, this form must also be signed by the child's primary physician

_____ _____

Health Care Provider Signature Date

_____ _____

Parent or Guardian Signature Date