Child Allergy Information Form

DATE	PROGRAM NAME		
CHILD'S FIRST NAME	MI	LAST NAME	DATE OF BIRTH

Allergy information

Describe the allergy. Allergies with similar symptoms can be listed together. Additional section(s) can be added for multiple allergies with different triggers, symptoms, and techniques.

What triggers the allergy?

All symptoms below may be experienced when exposed to an allergen. Please select any known symptoms the child may display:

- ☐ **No history of symptoms or unknown**
- ☐ **Mouth: Itching; tingling; swelling of lips, tongue or mouth ("mouth feels funny")**
- ☐ **Skin: Hives; itchy rash; swelling of the face or extremities**
- ☐ **Gut: Nausea; abdominal cramps; vomiting; diarrhea**
- ☐ **Throat: Difficulty swallowing; hoarseness; hacking cough**
- ☐ **Lungs: Shortness of breath; repetitive coughing; wheezing**
- ☐ **Heart: Weak or fast pulse; low blood pressure; fainting; pale; blueness**
- ☐ **Other:**

IF NEEDED, PLEASE LIST ANY ADDITIONAL INFORMATION REGARDING SYMPTOMS

What techniques will be used to avoid an allergic reaction?

What procedures should be taken to respond to an allergic reaction for this child?

Medications for responding to an allergic reaction

Are medications required for response to an allergic reaction for this child? ◯ Yes ◯ No

MEDICATION	DOSAGE

If Medication is required for an allergic reaction that is given by YMCA child care staff additional forms must be filled out. Please ask for form.

Doctor information - Call 911 for EMERGENCIES

DOCTOR NAME	DOCTOR PHONE NUMBER

Parent/Guardian Signature: _____ Date:_____