Allergy Information and Action Plan

Child's name: _____ DOB: _____

Child's current weight: _____

Physician name: _____ & Phone # _____

Known food allergies:

1) _____ ☐ mild ☐ moderate ☐ severe (please check one)

Treatment: _____ Action plan: _____

When did you first learn of this allergy? _____

Please explain: _____

2) _____ ☐ mild ☐ moderate ☐ severe (please check one)

Treatment: _____ Action plan: _____

When did you first learn of this allergy? _____

Please explain: _____

3) _____ ☐ mild ☐ moderate ☐ severe (please check one)

Treatment: _____ Action plan: _____

When did you first learn of this allergy? _____

Please explain: _____

4) _____ ☐ mild ☐ moderate ☐ severe (please check one)

Treatment: _____ Action plan: _____

When did you first learn of this allergy? _____

Please explain: _____

Does your child have an Epi-pen? Yes No

****Please attach supporting documentation from your physician.**

☐ I do ☐ I do not give permission for the school nurse or director's at FUMC Preschool/Parents' Day Out to administer Benadryl (antihistamine) to my child in the event of an allergic reaction in an emergency situation.

Parent(s) signature _____ phone # _____

Date: _____ ***Please see back for other allergies if needed.

Other known allergies:

1) _____

Treatment: _____ Action plan: _____

2) _____

Treatment: _____ Action plan: _____

3) _____

Treatment: _____ Action plan: _____

4) _____

Treatment: _____ Action plan: _____