2017 - 2018

ALLERGIES AND MEDICATION
(To be filled out by parent)

Name: _____ Date: _____

Food Allergies:

Is child allergic to any foods? If so, please name and describe allergic reaction. Be specific about child's age when reaction occurred.

Medical Allergies:

Is child allergic to any medicines? If so, please name and describe allergic reaction. Be specific about child's age when reaction occurred.

Has child ever received penicillin? Yes No

Has child ever had allergic reaction to penicillin? Yes No

Date: _____

Describe:

Current Medical Status

Does child have any important medical problems?

Please describe:

Please name doctor caring for this: _____

Is child receiving medication of any sort? Yes No

If yes, name of drug(s): _____

Amount of dosage: _____ Frequency of administration: _____

Reason for use: _____

Possible reaction to medication: _____

Name of doctor managing medication: _____