Date _____ **Child's Name** _____

Class _____

Allergy & Medical Information

Does your child have any allergies or sensitivities? **O Yes** **O No**

If Yes, please list below and indicate the reaction, treatment & details.

Food or Irritant	Reaction	Treatment	Details
			May be consumed if : • Raw Y N • Cooked Y N • Produced in a facility that handles Y N **May be touched?** Y N **Other:**
			May be consumed if : • Raw Y N • Cooked Y N • Produced in a facility that handles Y N **May be touched?** Y N **Other:**
			May be consumed if : • Raw Y N • Cooked Y N • Produced in a facility that handles Y N **May be touched?** Y N **Other:**

Is there a history of allergic reactions in your family that we should be aware of, that may affect your child? If Yes, please list.

_____

_____

Parent/Guardian - Name_____ **Signature** _____

NOTES

Date	Notes