TENDER YEARS ACADEMY CENTER
ALLERGY STATEMENT
(Please print in ink)

Child Name__________________________ Parent Name _________________________

*IF THERE ARE NO ALLERGIES KNOWN AT THIS TIME, PLEASE WRITE "**NONE**", SIGN BELOW, AND RETURN.*

NATURE OF ALLERGY (i.e. hay fever):

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Food(s) Child is allergic to:	Substitute:
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

PLEASE INDICATE THE SYMPTOMS OF THE ALLERGY:

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Licensing requirements state in WAC 388 150 240 (5) "The licensee may provide the child nutrient concentrates, nutrient supplements, a modified diet, or an allergy diet only with written permission of the child's health care provider."

HEALTH CARE PRACTITIONER____
(PRINT NAME/TITLE)

ADDRESS ____

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(SIGNATURE OF HEALTH CARE PRACTITIONER)

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(SIGNATURE OF PARENT)