Children With Allergies Form

Child's Name

Date of Birth Gender Other Allergy

Allergens

(PLEASE USE BLANK SPACES FOR ANY ADDITIONAL SIGNS)

Please select as many options as you need

- ☐ Rubbing face & eyes
- ☐ Agitated or unsettled
- ☐ Redness of skin
- ☐ Rash or hives over body
- ☐ Warmth and swelling of skin
- ☐ Itchy eyes, sneezing or coughing
- ☐ Itching lips throat or tongue
- ☐ Noisy breathing (Wheezing)
- ☐ Swelling of lips throat & tongue
- ☐ Tightness in chest and/or throat

Other Symptoms

- ☐ Difficulty swallowing
- ☐ Shortness of breath
- ☐ Difficulty talking
- ☐ Difficulty breathing
- ☐ Loss of consciousness

Has your child ever experienced an anaphylactic reaction? Not Sure

If your child suffers from a severe food allergy, an individual management plan will be developed in consultation with you. This will include the collection of extensive information.

If your child's allergy is not severe is there any other information you would like us to be aware of?

Parent's Name Email

Date

PLEASE ATTACH A LETTER FROM THE CHILD'S DOCTOR TO THIS FORM.

Please note: Prescription medicine will not be administered if labelled for anyone other than the child named on this form. Please ensure the medication (prescribed and over the counter) is clearly labeled with your child's name, Date of Birth and dosage, frequency required.

For more information refer to Medical Conditions Policy, Administration of Authorised Medication Policy located in the links on the enrolment page.