

Allergy Treatment Plan

Child's Details

Child's name _____ D.O.B. ____ / ____ / ____

Allergy Symptoms

Allergic to: _____

Usual reaction: _____

Reaction is: MILD MODERATE SEVERE

Allergy Treatment

Does your child take any medication to treat the reaction? Yes No

If **YES** what medication do they usually take?

Medication: _____ Dosage _____

How often? _____

Has your child been prescribed an **EpiPen**? Yes No

If **YES**, you will be required to supply us with one.

If your child does not require medication for the reaction what is the usual treatment?

Your **emergency** contact number: _____

Name _____

Signature _____ Date ____ / ____ / ____