



**Parent/Guardian:** You have been asked to complete this form to provide additional details regarding your child/ward's life threatening allergy. Please complete this form in full and return it along with a letter from your child/ward's physician diagnosing the allergy and its severity.

Please return the completed form to the centre Supervisor and work with her to complete the A.2 Individual Anaphylaxis Emergency Plan and the A.3 Epinephrine Consent & Administration Form.

**Child**

Name \_\_\_\_\_ Birth Date (MM/DD/YYYY) \_\_\_\_\_

**Home Address**

No. \_\_\_\_\_ Street \_\_\_\_\_ Apt. No. \_\_\_\_\_ P.O. Box or R. R. No. \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

**Parent/Guardian Phone Numbers:**

Mom Home \_\_\_\_\_ Business/Cell \_\_\_\_\_  
Dad Home \_\_\_\_\_ Business/Cell \_\_\_\_\_

**Emergency Contacts (Other than parents/guardians)**

<i>Name</i>	<i>Home Phone</i>	<i>Work Phone</i>	<i>Cell Phone</i>
_____	_____	_____	_____
_____	_____	_____	_____

**Specific Potentially Life-threatening Allergy(ies)**

\_\_\_\_\_

\_\_\_\_\_

**Nature of the Reaction**

\_\_\_\_\_

\_\_\_\_\_

**Recommended Treatment in the Event of Accidental Exposure**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**This form was completed by:**

_____	_____	_____	_____
Print Name	Signature	Relationship to Child	Date Completed

Tip: Use Tools> Fill & Sign to type or draw your signature.