

**Allergy/Intolerance  
Statement**

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

**(Please print)**

<b>Food Allergy: List each food separately</b>	<b>Check the medical condition</b>	<b>List appropriate substitute food(s)</b>
	Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Yes    No Food Allergy <input type="checkbox"/> <input type="checkbox"/> *Yes    No	
	Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Yes    No Food Allergy <input type="checkbox"/> <input type="checkbox"/> *Yes    No	
	Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Yes    No Food Allergy <input type="checkbox"/> <input type="checkbox"/> *Yes    No	
	Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Yes    No Food Allergy <input type="checkbox"/> <input type="checkbox"/> *Yes    No	

<b>Other Allergy: Please list items:</b>	<b>Reaction:</b>	<b>Plan for management:</b>
	Mild <input type="checkbox"/> <input type="checkbox"/> Yes    No Severe <input type="checkbox"/> <input type="checkbox"/> Yes    No	

**\* For an Allergy, please complete the Child Care Emergency Plan for Allergic Reactions.**

Health Care Provider Name \_\_\_\_\_

Health Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Mailing Address (Print) \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Please return to the child care program at the address listed below:**

\_\_\_\_\_

