



# Allergy Management

Child's Surname: \_\_\_\_\_

Child's First Name (s): \_\_\_\_\_

What is/are the child's allergy(s)?

What triggers the allergy(s)?

What are the symptoms of an attack?

Please specify the treatment required:

Please ensure you have completed a Medicine Form if necessary.

Signature of parent/carer: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_