# Allergy & Asthma Form

**Childs Name:** _____ **Date of Birth:**_____

**Does your child have any allergies?** ☐ **Yes** ☐ **No**
If Yes, please list, and indicate type of reaction.

| **FOOD** | **REACTION** |
| --- | --- |
| _____ | _____ |

| **MEDICATION** | **REACTION** |
| --- | --- |
| _____ | _____ |

| **INSECTS** | **REACTION** |
| --- | --- |
| _____ | _____ |

**Does your child suffer from any other allergies, eg. Chemical, first aid creams/lotions, plants, animals?** ☐ **Yes** ☐ **No**
If Yes, please list, and indicate type of reaction.

_____

(If your child's reaction is severe please supply the centre with medical advice from your doctor.)

**Is there a history of allergic reactions in your family that we should be aware of, that may affect your child?** ☐ **Yes** ☐ **No**

_____

**Does your child suffer from Asthma?** ☐ **Yes** ☐ **No**
(If YES, please supply the centre with medical advice.)