BISHOP RYAN CATHOLIC SCHOOL

ALLERGY INFORMATION

Student Information

_____ _____

Child's Name Date of Birth

_____ _____

Child's Grade School Year

Allergy Information

Please list all allergies your child has:

_____

_____

Please list allergy medication(s):

_____

_____

_____

Please list steps to take if your child comes in contact with an allergen:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

Emergency Contacts

_____ _____

Primary Emergency Contact Cell/Home/Work/Other Phone Number

_____ _____

Relationship to Child Cell/Home/Work/Other Phone Number

_____ _____

Second Emergency Contact Cell/Home/Work/Other Phone Number

_____ _____

Relationship to Child Cell/Home/Work/Other Phone Number

_____ _____

Third Emergency Contact Cell/Home/Work/Other Phone Number

_____ _____

Relationship to Child Cell/Home/Work/Other Phone Number

_____ _____

Parent Signature Date

For Office Use Only:

Does the office have the medication? Yes/No

Do we have a completed Medication Consent Form? Yes/No