ANAPHYLAXIS EMERGENCY FORM

(One form per child - ONLY for those participants with life-threatening allergies)

Child's Name:		**PLACE CHILD'S PHOTO HERE** **(REQUIRED)**
Address:		
Home Phone #	**Date of Birth**	
Name of Father	**Business #**	
Name of Mother	**Business #**	
Emergency Contact	**Phone #**	

PHYSICIAN INFORMATION (to be completed by Family Physician**)**

Allergy Description:
The above named child has a dangerous, life-threatening allergy to the following:

- ☐ **foods** _____
- ☐ **and all foods containing them in any form in any amount, including the following kinds of items:**_____
- ☐ **bee/insect stings**
- ☐ **medications** _____
- ☐ **latex**
- ☐ **vigorous exercise**

Symptoms of Reaction:

EMERGENCY RESPONSE PLAN

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Recommended Response to Reaction:

Medication: **Dosage:**

Additional Instructions or Information:

Name of Physician: **Telephone:**

Signature of Physician: **Date:**