

Randolph County BOE Head Start
Allergy Form

Child's Name: _____

Please list any of your child's allergies and any medical conditions that your child may have. **We must have a written statement from your child's doctor stating that he/she has the following allergies.**

Food:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

7. _____
8. _____
9. _____
10. _____

Any other substance that may cause an allergic reaction:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

I give permission for my child's name to be posted in the classroom and cafeteria as a reminder to staff to prevent allergic reactions. This is very important to keep your child as safe as possible and involved in a healthy environment. A copy of this form will be given to your child's teacher, health manager, and cafeteria staff.

Parent's Signature: _____

Date: _____