

## ANAPHYLAXIS EMERGENCY FORM

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

<b>Child's Name:</b>		<b>PLACE CHILD'S PHOTO HERE  (REQUIRED)</b>
<b>Address:</b>		
<b>Home Phone #</b>	<b>Date of Birth</b>	
<b>Name of Father</b>	<b>Business #</b>	
<b>Name of Mother</b>	<b>Business #</b>	
<b>Emergency Contact</b>	<b>Phone #</b>	
<b>PHYSICIAN INFORMATION</b> (to be completed by Family Physician)		
<b>Allergy Description:</b> The above named child has a dangerous, life-threatening allergy to the following: <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>foods</b> _____</li> <li><input type="checkbox"/> <b>and all foods containing them in any form in any amount, including the following kinds of items:</b>_____</li> <li><input type="checkbox"/> <b>bee/insect stings</b></li> <li><input type="checkbox"/> <b>medications</b> _____</li> <li><input type="checkbox"/> <b>latex</b></li> <li><input type="checkbox"/> <b>vigorous exercise</b></li> </ul>		
<b>Symptoms of Reaction:</b>		
<i><b>EMERGENCY RESPONSE PLAN</b></i>		
<b>Recommended Response to Reaction:</b>		
<b>Medication:</b>	<b>Dosage:</b>	
<b>Additional Instructions or Information:</b>		
<b>Name of Physician:</b>		<b>Telephone:</b>
<b>Signature of Physician:</b>		<b>Date:</b>