

ALLERGY & INTOLERANCE ACCOMMODATION FORM

CHILD'S NAME: _____ D.O.B. _____
CLASS/TEACHER: _____

** I, _____, parent or legal guardian of the above child authorize doctor listed below to release information regarding my child's allergies/intolerance, medication taken for allergies/intolerance and any substitutions used in the case of food allergies/intolerance to GKB Head Start & Early Head Start.**

Parent Signature _____ Date _____

Completed By Child's Physician:

- THIS CHILD HAS A DIAGNOSED ALLERGY.
 THIS CHILD HAS A DIAGNOSED FOOD INTOLERANCE.

Child's Allergy: _____
Child's Reaction: _____
Substitutions (if food allergy): _____
Medications: _____
 Not Applicable

Child's Allergy: _____
Child's Reaction: _____
Substitutions (if food allergy): _____
Medications: _____
 Not Applicable

Child's Intolerance: _____
Child's Reaction: _____
Food Substitutions: _____
 Not Applicable

Doctor's Printed Name: _____

Doctor's Signed Name: _____

Doctor's Phone: _____