

# 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: \_\_\_\_\_