KIDSENSE THERAPY GROUP
ALLERGY ALERT FORM

INSTRUCTIONS: PLEASE COMPLETE AND RETURN THIS FORM PRIOR TO YOUR FIRST VISIT.

Child's Name: _____

Primary Emergency Contact (Name/Phone #):

_____

Full Name *Telephone Number*

Secondary Emergency Contact (Name/Phone #):

_____

Full Name *Telephone Number*

Does the client have any known allergies (i.e. to foods, medicines, environmental agents)? If so, please list each allergen and describe the client's response to contact with the allergen(s).

Please describe immediate action to be taken in case of contact with allergen(s).

Person completing form: _____

Relationship to client: _____ Date: _____