

# Northern Michigan University Allergies Information Form

Please complete the following information:

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Parent's/Guardian's Name(s) \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

1. Please describe your child's condition or diagnosis. \_\_\_\_\_  
\_\_\_\_\_
2. Describe any allergy/ies? (Specify inhalants, medications, bee sting, animals, food,...)  
\_\_\_\_\_  
\_\_\_\_\_
3. What kind of reaction does your child experience? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Does your child receive allergy shots? Yes \_\_\_\_\_ No \_\_\_\_\_
5. What medications does your child take for his/her allergies? \_\_\_\_\_  
\_\_\_\_\_
6. Please describe any other concerns you have regarding your child's allergies and participation in this program. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you for providing this information. It will be given to the program staff to help meet your child's needs.*