Allergy Management Plan

Child's name: **Date of birth:** **Address:**	Attach photo here

Doctor's name:

Doctor's address:

Allergy to / triggered by?

Please circle if affected by any of the below:

Celery Gluten Crustaceans Eggs Fish Lupin Milk Molluscs Mustard Nuts peanuts Sesame seeds soya sulphites

Reactions/symptoms include:

Treatment:

Medicine form attached? Yes ☐ No ☐ **(tick as appropriate)**

Parent / Carer's name:

Contact details:

mytimeactive