****

**Allergy Management Plan**

|  |  |
| --- | --- |
| Child’s name:  Address:  Date of birth: | Attach photo here |
| Doctor’s name:  Doctor’s address: | |
| Allergy to / triggered by? | |
| Reactions/symptoms include: | |
| Treatment:  Medicine form attached? Yes □ No □ (tick as appropriate) | |
| Parent / Carer’s name:  Contact details: | |