YMCA Loudoun County

ALLERGY FORM

If your child has allergies, please complete all blanks on this form. Incomplete forms cannot be accepted. We are unable to provide care until all paperwork has been submitted.

Child's Full Name		Date of Birth
Height	Weight	Sex

PARENTS/GUARDIAN INFORMATION

Parent/Guardian Name	Cell Phone	Work Phone
Parent/Guardian Name	Cell Phone	Work Phone

MEDICAL/INSURANCE INFORMATION

Physician Name:	Physician's Phone
Insurance Policy Name	Insurance ID/Group

ALLERGIES (check any allergy below and provide specific allergy in space provided)

☐ Food: ______________________________

☐ Medication: ______________________________

☐ Environmental: ______________________________

☐ Other: ______________________________

INSTRUCTION IF ALLERGIC REACTION OCCURS

MEDICATION

By my signature I am stating that the information is completed and accurate to my knowledge.

______________________ ______________
Physician Signature Date

______________________ ______________
Parent/ Guardian Signature Date