

CHILD'S ALLERGY REPORT

Name: _____ Date: _____

Physician: _____ Phone: _____

This child has been diagnosed as allergic to: _____

He/She displays the following reactions: _____

The diagnosis was made by:

_____ Skin Test _____ Challenge Test _____ RAST Test _____ History

Has the child been referred to or treated by an allergist? _____

Name: _____ Address: _____

If food is restricted, do you expect any nutritional deleterious effects?

Recommended nutritional supplements: _____

Does the child need to be referred to a registered dietician? _____

Physician's Signature