

**Pupil Allergy Information**

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| **Name:** | | **D.O.B.** |
| **Allergy / Intolerance** | | |
| **Medically Diagnosed Yes No** | | |
| **Are they under Medical Supervision for the Allergy/Intolerance?**  (If yes, please give details of what this involves) | | |
| **Reaction to named foods** – signs and symptoms to look out for | | |
| **Signed:** | **Date:** | |