5960 Fairview Road, Suite 300
Charlotte, NC 28210
Tel: 704-441-8715
www.autism-180.com
info@autism-180.com

Allergy Form

Child's Name: ……………………………………………..

Date of Birth: ……………………………………………..

Please list any of your child’s allergies and any medical conditions that your child may have.

Food:

Medication:

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Any other substance that may cause an allergic reaction:

If my child has an allergy, I authorize my child's name may be posted in the therapy rooms as a reminder to staff to prevent allergic reactions. This is very important to keep your child as safe as possible and involved in a healthy environment.

Parent/Guardian's Signature: