Boys & Girls Club of the Bemidji Area

ALLERGY/MEDICATION FORM

Member Full Name: ______________________________

Member DOB: ______________ 2019/2020 Grade: ______________

Parent/Guardian Name: ______________________________

Phone Numbers: Cell ____________ Home ____________ Work ____________

Doctor Name: ______________________ Phone: ______________

______________________________ ______________

Parent/Guardian Signature Date

ALLERGY 1

Allergy: ______________________ Description: ______________________

Triggers: ______________________________

Avoidance Techniques: ______________________________

Reaction Symptoms: ______________________________

Responding to allergic reaction: ______________________________

Medication: ______________________ Dosage: ______________

ALLERGY 2

Allergy: ______________________ Description: ______________________

Triggers: ______________________________

Avoidance Techniques: ______________________________

Reaction Symptoms: ______________________________

Responding to allergic reaction: ______________________________

Medication: ______________________ Dosage: ______________

MEDICATION 1

Medication : ______________________________

Medication is for: ______________________________

Dosage on medication: ______________________________

Medication must be in original container with child's first & last name and can not be expired.

MEDICATION 2

Medication : ______________________________

Medication is for: ______________________________

Dosage on medication: ______________________________

Medication must be in original container with child's first & last name and can not be expired.