



ALLERGY AND FOOD SENSITIVITY INFORMATION FORM

General Information

Child's Name:		Social security number:	
Parent(s)/Guardian(s):		Phone Number (which can always be reached):	
Parent(s)/Guardian(s):		Phone Number (which can always be reached):	
Class/Department:		Playschool Teacher:	

Type of Allergy/ Food Sensitivity:

<input type="checkbox"/> Peanut allergy		<input type="checkbox"/> Tree nut allergy	
<input type="checkbox"/> Fish allergy		<input type="checkbox"/> Shellfish allergy	
<input type="checkbox"/> Egg allergy		<input type="checkbox"/> Flour allergy	
<input type="checkbox"/> Gluten intolerance		<input type="checkbox"/> Lactose intolerance	
<input type="checkbox"/> Kiwi allergy		<input type="checkbox"/> Citrus fruit allergy	
<input type="checkbox"/> Other: _____			
Anaphylaxis? Yes <input type="checkbox"/> No <input type="checkbox"/>		Epinephrine auto-injector at office? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Child has it in school bag? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Period (temporary situation) Date: _____ / _____ 20__ __		Medical certificate Yes <input type="checkbox"/> No <input type="checkbox"/>	
Short description of allergy/food sensitivity:			
_____ Place and date		_____ Signature of Parent/Guardian	

Please note: This information must be renewed yearly



EYÐUBLAÐ VEGNA OFNÆMIS EÐA FÆÐUÓÞOLS

Almennar upplýsingar

Nafn barns:	Kennitala:
Nafn foreldris/forráðamanns:	Símanúmer sem <u>alltaf</u> er hægt að ná í:
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Bekkur/deild:	Leikskólakennari:

Tegund ofnæmis/óþols:

<input type="checkbox"/> Jarðhnetuofnæmi	<input type="checkbox"/> Trjáhnetuofnæmi	
<input type="checkbox"/> Fiskofnæmi	<input type="checkbox"/> Skelfiskofnæmi	
<input type="checkbox"/> Eggjaofnæmi	<input type="checkbox"/> Hveitiofnæmi	
<input type="checkbox"/> Hveiti/glútenóþol	<input type="checkbox"/> Mjólkuróþol	
<input type="checkbox"/> Kívíofnæmi	<input type="checkbox"/> Sýtrusofnæmi	
<input type="checkbox"/> Annað: _____		
Bráðaofnæmi? Já <input type="checkbox"/> Nei <input type="checkbox"/>	Ofnæmissprauta á skrifstofu? Já <input type="checkbox"/> Nei <input type="checkbox"/>	Fylgir barni í tösku? Já <input type="checkbox"/> Nei <input type="checkbox"/>
Tímabil (tímabundið ástand) Dagsetning: _____ / _____ 20 __ __	Læknisvottorð Já <input type="checkbox"/> Nei <input type="checkbox"/>	
Stutt lýsing á ofnæmi/óþoli:		
_____	_____	
Staður og dagsetning	Staðfesting foreldris/forráðamanns	

Athugið: Endurnýja þarf árlega ofangreindar upplýsingar.