

**Keyingham
Out of School Club
Allergy Management Plan**

Child's name: Address: Date of birth:	Attach photo here
Doctor's name: Doctor's address:	
Allergy to / triggered by?	
Reactions/symptoms include:	
Treatment: Medicine form attached? Yes <input type="checkbox"/> No <input type="checkbox"/> (tick as appropriate)	
Parent / Carer's name: Contact details:	

