

# IBTS

## Allergy Management Plan

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