

# My Allergies

Name: \_\_\_\_\_

Food Allergies	
Allergic to:	Medication prescribed:

Natural/Seasonal Allergies	
Allergic to:	Medication prescribed:

Animals	
Allergic to:	Medication prescribed:

Medications	
Allergic to:	Medication prescribed:

Other Allergies	
Allergic to:	Medication prescribed:

Physician information
Name:
Address:
Phone: