

# Innovative Therapy Services

Pediatric Speech-Language Services



*Expect the Best in Learning Speech & Social Language Skills*

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## Allergy Alert Form

Date: \_\_\_\_\_

Client's Name: \_\_\_\_\_

Person to Contact In Case of Emergency: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Does the client have any known allergies (e.g. to foods, medicines, environmental agents)? If yes, please list each allergen and describe the client's response to contact with the allergen(s).

Please describe immediate action to be taken in case of contact with allergen(s).

Signature of person completing form: \_\_\_\_\_

Relationship to client: \_\_\_\_\_