

**UPWARD BOUND**  
**Student Allergy and Medication Form**  
**This needs to be completed entirely by a parent/guardian**  
**(Even if items are selected NO)**

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

<b>Is your child a diabetic?</b>	<b>Yes</b> <b>No</b>
<b>If yes, any special instructions?</b>	
<b>Does your child have any FOOD allergies?</b>	<b>Yes</b> <b>No</b>
<b>If yes, what allergies?</b>	
<b>Is your student gluten free?</b>	<b>Yes</b> <b>No</b>
<b>Is your student lactose intolerant?</b>	<b>Yes</b> <b>No</b>
<b>Is your student on any current medications?</b>	<b>Yes</b> <b>No</b>
<b>If yes, please lists all medications:</b>	
<b>Is your student ALLERGIC to any medications?</b>	<b>Yes</b> <b>No</b>
<b>If yes, please list these medications:</b>	

Any other medical information you feel UB staff should be aware of, please note on the back of this form.

\_\_\_\_\_

PARENT SIGNATURE

\_\_\_\_\_

DATE