Date: [Insert Date]

Patient Name: [Insert Child's Name]
Appointment Date: [Insert Date]
Appointment Time: [Insert Time]
Location: [Insert Clinic Address/Suite]

Dear Parent/Guardian of [Insert Child's Name],

This is a reminder regarding your child's upcoming pediatric allergy testing appointment. To ensure accurate test results, please follow these instructions carefully:

- **Antihistamines:** Your child must stop taking all antihistamines (such as Benadryl, Zyrtec, Claritin, or Allegra) at least [Number] days before the appointment.
- **Duration:** Please plan to be at our office for approximately [Number] hours.
- **Food/Comfort:** You may bring small snacks, drinks, and a favorite toy or tablet to keep your child comfortable during the observation period.
- **Clothing:** Please have your child wear a short-sleeved shirt or loose clothing, as testing is typically performed on the back or arms.

If your child is currently taking any new medications or has had a recent asthma flare-up, please call our office prior to your arrival.

If you need to reschedule or cancel, please provide at least [Number] hours' notice to avoid a cancellation fee.

Sincerely,

[Insert Doctor/Clinic Name]
[Insert Phone Number]
[Insert Website/Portal]