

STUDENT ALLERGY INFORMATION

Chippewa Intermediate School

Student's Name _____

Student's Date of Birth _____ School Year 2018-2019 Grade _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

The student listed above is under my care and should receive the following:

Allergic to:	Special Requirements for Student at School

Should a change in any of the above information occur, a revised written physician's statement must be submitted to the school.

Physician's Printed Name Physician's Signature Physician's Phone # Date

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby request and give my permission to the Principal or designee to provide adaptations at school for my child with allergies, including differentiated seating.

Parent's Printed Name Parent's Signature Parent's Phone # Date