BEE STING/FOOD ALLERGY

Date _____

Dear Parent/Guardian:

According to our emergency file, _____ is allergic to _____ Please have your family physician complete the lower portion of this form. Please return this information to me as soon as possible.

If reaction requires medication, please send the medication to school to be kept in the Health Room. Schools do not have medicine in stock.

Cordially,

Certified School Nurse

REPORTS FROM FAMILY PHYSICIAN

Date_____

Name_____ School_____

Bee Sting Allergy Yes _____ No_____ Food Allergy _____
(Type)

Treatment/Medication prescribed (to be supplied by parent) _____

Dosage _____

How is medication to be given? _____

Comment _____

Physician's Signature _____ Phone _____

Parent/Guardian Signature _____

Return This Form to: _____, Certified School Nurse

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Revised 2/03