Chippewa Local Schools
STUDENT ALLERGY INFORMATION
(only needs to be filled out if your child has a known allergy)

Student's Name _____ School _____

Student's Date of Birth _____ School Year _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

_____ is under my care and should receive the following:
(Name of Student)

Allergic to:	Special Requirement 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 Phone # Physician's Signature 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 Phone # Parent's Signature Date

School Use: Date Received: _____ Received by: _____