STUDENT ALLERGY INFORMATION

Chippewa Middle School

Student's Name _____ School Chippewa Middle School

Student's Date of Birth _____ School Year _____ 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