

**PHYSICIAN INFORMATION FORM FOR ANAPHYLAXIS**

**STRATEGIES IN PREVENTION AND MANAGEMENT OF ANAPHYLAXIS IN THE SCHOOL SETTING**

(Parent(s) / guardian(s) requests physician to complete and sign this form.)

Student Name: \_\_\_\_\_

Specific potentially life-threatening allergens. \_\_\_\_\_  
\_\_\_\_\_

The nature of the reaction (Check all applicable).

- Physical contact with this allergen may cause an anaphylactic reaction.
- Airborne contact with this allergen may cause an anaphylactic reaction.
- Ingestion of food may cause an anaphylactic reaction.
- Other (Please explain below):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recommended treatment in the event of accidental exposure.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ (Physician)

Date: \_\_\_\_\_ (Witness)

**(This will be filed in the student's record and information will be shared, with parental consent, on a "needs to know" basis)**