

# Tift County Schools

## ALLERGY INFORMATION & INSTRUCTIONS

Child's Full Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

The following document must be completed by the child's physician (as frequently as the needs of the child change).

The purpose of this information is to guide the school's actions if the child is exposed to the item he/she is allergic to. The more information we have, the better we can serve you and care for your child.

**Therefore, Please do NOT use this form for food intolerances.**

Please complete and return:

<b>What the child is allergic to Note: if milk or egg allergy, please tell us if this includes baked goods, etc.</b>	<b>Type of exposure (Skin contact, swallowing, etc.)</b>	<b>Response to observe for</b>	<b>Actions to be taken for each level of response that may occur</b>

The above instructions are provided by:

\_\_\_\_\_  
Physician's Signature Date

I agree with the physician's instructions:

\_\_\_\_\_  
Parent/Guardian Signature Date

A COPY OF THIS FORM WILL BE POSTED IN THE KITCHEN (IF FOOD RELATED), PROVIDED TO THE CLINIC AIDE, PLACED IN THE CHILD'S PERMANENT RECORD, AND MAY BE POSTED IN THE CHILD'S CLASSROOM.