Lockport Township High School District 205
Authorization for Emergency Care
of Students with Allergies

Dear Doctor: _____ **Date:** _____

Your patient, _____, is enrolled in Lockport Township High School District 205, and we have been requested to provide certain emergency care in the event that the child comes into contact with a certain allergen(s) as described below. Please complete this form, describing the treatment needed for the allergy described. This will become a part of the child's health file at school.

To be completed by physician:

Child's Name: _____ Birth Date: _____

Allergens:

Please provide a complete list of all substances that may trigger an allergic reaction in the child.

_____Bee Sting

_____Other Insect Bite: (Identify) _____

_____Animal: (Identify)

_____Food Allergy: (Identify all foods that must be avoided) _____

_____

_____Other: (Identify) _____

Parent or Guardian Signature: _____

Date: _____