Watertown-Mayer Public Schools • ISD #111
Kids' Company & Caring Hands Child Care

Severe Allergy Information

______________________________ ________ _______ _____ / _____ / _____
Student's Name **Grade** **Age** **Date of Birth**

Allergy/s:	
Triggers	
Avoidance Techniques	
Symptoms of Allergic Reaction:	
Procedures for Responding to Allergic Reaction:	

All Prescription medications require a **parent/guardian signature AND physician's signature and Medication Authorization Form**

Medication	Dosage	Possible Side Effects

Other Considerations/Directions:

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Physician Information:

Doctor:: ________________________________ Clinic: ____________________

Phone#: ___________________________ Fax#:_________________________

______________________________________ ____________________
Parent/Guardian Signature Date