Howard-Winneshiek Community School District
Allergy Alert Form

Student Name_____ DOB_____
has an allergy / intolerance to:_____
(Circle one)

If student is exposed to the above stated allergen the student may have the following symptoms: _____
_____
_____

Please list the plan of treatment if the student is exposed to the above stated allergen: _____
_____
_____
_____
_____

_____ _____
Physician's Signature Date

_____ _____
Physician's Telephone Number Fax Number

I request that this medication/procedure be administered at school, pertinent information be shared with school staff, and school staff may contact my child's doctor if necessary. Medication will be supplied in its original container. This order is in effect for this school year. I will notify the school of any changes and obtain a new physicians order. I release the school district from liability claims as a result of the administration of this medication or procedure as directed.

_____ _____ _____
Parent/Guardian Signature Date Phone Number