Allergy Alert

Child’s Name: ___________________________ Child’s Classroom: _____________

Please check and sign one of the following statements:

☐ My child has an allergy or sensitivity to the following:

__________________________________________________
__________________________________________________

The above indicated allergens/sensitivities need to be managed in my child’s environment. I agree to complete and submit the Allergy Action Plan for my child, provided to me by NFCNS. I further agree to provide the medications necessary to manage my child’s allergy/sensitivity at school, and to complete the forms authorizing NFCNS staff to administer such medications should they be indicated.

_________________________________________  __________________________________
__________ (parent/guardian name)          (signature)           (date)

☐ To my knowledge, my child has no allergies or medical conditions that need to be managed at NFCNS.

_________________________________________  __________________________________
__________ (parent/guardian name)          (signature)           (date)