Food Allergy and/or Medication Emergency Plan

This plan must be signed and dated by your child's Health Care Professional.

Child's Name:_____ Date of Birth:_____

Doctor: _____

Address: _____

Phone: _____ Fax:_____

Food(s) child is allergic to, or medical issue	**Possible symptoms if child is exposed to this food, or symptoms of medical issue**	**Steps to take if child has an allergic reaction, or medical issue**

By signing below, the parent or guardian of this child gives Child Enrichment Center permission to post the child's food allergy in any area where food is served or prepared.

Dr. Signature:_____Date:_____

Parent or Guardian Signature:_____Date:_____

Center Director Signature:_____Date:_____

Office use only: _____Classroom _____Emergency Evacuation Binder _____Field Trip Folder