



## 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*