I have Allergies and/or Asthma…

Date: _____

My Name is: _____

I am in the _____ **Classroom**

I am allergic to: _____

_____

I am asthmatic: Yes ☐ No ☐

I am at High Risk for a reaction: Yes ☐ No ☐

I have emergency medication: Yes ☐ No ☐

I have an EpiPen ☐ / Inhaler ☐ / Nebulizer ☐ / Other: _____ (circle all that apply)

Please watch me for these symptoms: _____

_____

Place Child's

Photo Here

Please Note:

A child in this classroom is allergic to:

_____