The Community School of West Seattle

Allergy Plan. This form must be submitted to your Health Care provider.

Child's Name_____Date of Birth_____

- **To the Health Care provider of the above named child.**

Please help us meet the particular health needs of this child by completing the following information. Thank You.

Sarah Airhart, Director.

The child named above is

ALLERGIC to:*	If food item what is a nutritional substitution	REACTION:	TREATMENT:

*****For ALLERGIES please also complete the **Emergency Plan for allergic reactions** attached to this packet

The child named above has

INTOLERANCE to:	If food item what is a nutritional substitution	REACTION:	TREATMENT:

Health Care Practitioner's Signature_____

Health Care Practitioner's Name_____

Health Care Practitioner's Phone Number_____

Health Care Practitioner's Address_____

_____

Consent from Parent/Guardian.

I, _____(print name of parent/guardian) authorize the above named health care provider to release the requested information for the above named child to The Community School of West Seattle (CSWS)

Parent/Guardian Signature_____

Home address:_____

Phone Number_____Today's Date_____

- **Health Care Practitioner,** please return this form to:

CSWS - 9450 22nd Ave SW - Seattle, WA 98106

Phone: 206-763-2081 Fax: 206-762-2369