PHYSICIAN STATEMENT

School year 20___ - 20___

_____ (name of child) is seen in my office/clinic and I verify that he/she has life threatening allergies to _____(food) and requires an Epi-Pen to be kept at school.

_____ (name of child) was last tested _____(date)

Milford Exempted Village School District encourages regular medical evaluations for allergies. However, Milford Exempted Village School District requires **annual** physician statements regarding current food allergies.

_____(health care provider signature) _____(date)