Masais Playhouse ®

Allergy Verification Form

MASAI'S PLAYHOUSE LLC 24/7 Childcare, Infant Care and Preschool

I,_____ , hereby authorize the exchange and release of the following confidetial information regarding my child named below, to Masai's Playhouse LLC. for purposes of determining special exceptions to MPH LLC. illness policy when my child is experiencing allergy symptoms.

STUDENT INFORMATION

Student Name:_____

Gender: ☐ M or ☐ F Birth Date: ___/___/___

Certifying Physician Information

Physician Name and Specialty:

Address:_____

Phone:_____ Fax:_____

License/ Cert# and State:_____

Date of initial contact with student:_____

Date of last contact with student:_____

Current Diagnosis(specify each allergy confirmed by appropriate testing):

_____

_____

Symptoms exhibited upon exposure to allergen listed in diagnosis above

_____

_____

Please select any of the following which are true of your patient(attach supporting documentation):

- ☐ Allergies documented by skin testing or other diagnostic testing
- ☐ Prior or current immunotherapy (allergy shots)

Please detail appropriate treatment for student in the event of an allergy reaction:

_____

_____

Physicians Signature_____ **Date**_____