MAGICAL ADVENTURES LEARNING CENTER LLC

Allergy Action Plan AUTHORIZATION

TO BE COMPLETED BY PHYSICIAN

Child's Name:	**Date of Birth/Age:**
Allergy:	**Reaction:**

I give permission for the administration of the following for allergic reactions, including, but not limited to, calling 911 and/or transporting my child to the nearest hospital:

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Parent/Guardian Signature Date Daytime Phone Number

_____ _____

Physician Signature Date Daytime Phone Number