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)