

# ALLERGY AND ASTHMA SPECIALISTS, P.C.

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PATIENT: \_\_\_\_\_ D.O.B. \_\_\_\_\_ DATE: \_\_\_\_\_

## Dear Parents:

Please provide the following information for your school requirements. Do not leave your school forms as we will provide you with our own medication forms. All forms will be mailed home when completed. Please allow 10 days for this process.

## Medication (s) Requested:

Epi Pen Jr. 0.15 mg

Epi Pen 0.3 mg

Adrenaclick 0.15 mg

Adrenaclick 0.3 mg

Epi Pen Jr./Adrenaclick Jr. - (50 lbs. and under)

List allergies to foods/stinging insects, that Epi-pen/Adrenaclick is prescribed for.

Asthma Action Plan (ONLY NEEDED IF REQUESTED BY YOUR CHILD'S SCHOOL)

Please list all ASTHMA ONLY medications currently taking.

CAMP ONLY \_\_\_\_\_ Dates at Camp From: \_\_\_\_\_ to: \_\_\_\_\_