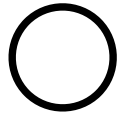


# SEVERE SYMPTOMS



# MILD SYMPTOMS

MPOC 2012/3/13/28/11/4/35/6/2/52/80/15/20

## MEDICATIONS/DOSES

0.1 mg IM    **V** 0.15 mg IM    **V** 0.3 mg IM

Antihistamine Brand or Generic:

Antihistamine Dose:

Other (e.g., inhaler-bronchodilator if wheezing):

### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD:

DOCTOR:

PHONE:

PARENT/GUARDIAN:

PHONE:

### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

School \_\_\_\_\_

Teacher \_\_\_\_\_

Grade: \_\_\_\_\_

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: \_\_\_\_\_

## Request for Dietary Accommodation

Please complete this form and provide a copy to the school cafeteria. The Parent /Legal Guardian and School Nurse will