



Allergy Removal Form

Date: _____

Student Name: _____

Student ID: _____

School: _____

The above student is **no longer** allergic to:

The above student is **still** allergic to:

Parent or Doctor Signature: _____

Parent or Doctor Name (Printed): _____

For Internal Use Only

(Dietitian) Date Received: _____ **Initials:** _____

(Nurse) Date POS Updated: _____ **Initials:** _____