Allergy Removal Form 2025-2026

Date: _____

Student Name: _____

Student ID: _____

School: _____

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

_____

_____

_____

Parent or Doctor Signature: _____

Parent or Doctor Name (Printed): _____

For Internal Use Only

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

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

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