DOCTOR ALLERGY LETTER

Patient Name: _____ Date of Birth: _____

Physician Information:

Full Name: _____

Medical License Number: _____

Office Address: _____

Phone/Email: _____

Allergy Diagnosis and Treatment:

This letter certifies that the above-named patient has been diagnosed with specific allergies that require medical attention and management. The patient exhibits allergic reactions to one or more of the following substances, which may include but are not limited to: pollen, dust mites, animal dander, foods, insect stings, medications, or other environmental factors.

Prescribed Medications and Instructions:

The patient is currently prescribed specific medications to manage allergic symptoms and prevent severe allergic reactions. These medications may include antihistamines, corticosteroids, epinephrine auto-injectors, and immunotherapy treatments. The patient is instructed to carry necessary medication at all times and to strictly adhere to the prescribed treatment plan.

Emergency Protocol:

In case of exposure to allergens resulting in anaphylaxis or severe allergic reaction, immediate administration of epinephrine and emergency medical care is required. The patient and caregivers have been educated on recognizing early signs of an allergic reaction and the appropriate emergency response.

Activity and Exposure Restrictions:

The patient should avoid known allergens and follow recommendations to minimize exposure, including but not limited to avoiding certain foods, environments, or activities where allergen exposure risk is high. These restrictions are critical to the patient's health and wellbeing.

Physician's Statement:

I hereby certify that the above information is accurate and complete to the best of my knowledge. This letter is provided for the purpose of informing relevant parties of the patient's allergy condition, treatment requirements, and necessary accommodations to ensure the patient's safety.

PHYSICIAN'S SIGNATURE

Signature: _____

PATIENT'S SIGNATURE

Signature: _____

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