LIFE THREATENING ALLERGIES AND ASTHMA – STUDENT INFORMATION SHEET

Name: ________________________________ Date of Birth ____________________ Date:________

School: _______________________________ Teacher: ________________________ Grade: _______

Parent(s) Names (s): ____________________________________ Home Phone: __________________

Doctor's Name: ____ Doctor's Phone: ________________

List and describe known allergies or suspected reactions to:

Foods/plants/others ____

Insects ____

Does he/she have allergies and/or asthma diagnosed by a doctor: Yes / No If yes, at what age? _______

Do you have a prescribed management plan? Yes / No **If yes, please attach a copy.**

Has your child ever been hospitalized with an allergic reaction and/or asthma? Yes / No Last visit:_____
Has your child ever been treated in the ER with an allergic reaction or asthma? Yes / No Last visit______
If yes, to either question, please describe:

____

____

Describe a typical allergic reaction and/or asthma attack:

____

____

What usually causes a reaction or an asthma attack?

____

____

What usually helps if a reaction or an asthma attack occurs?

____

____

Usual Daily Medications (name, dose, times): ____

____

Medications given frequently, but not daily? ____

____

Describe side effects your student experiences from these medications? _________________________

____

Does he/she know how to administer their own medications? _____________________________________

Revised 8/2012, 7/2017