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?  ______________________________________

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