AACA
ALPHONSUS
1439 W. Wellington Ave
Chicago, IL 60657
773-348-4629 PH
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CARE PLAN FOR STUDENT WITH FOOD ALLERGIES

Student's Name_____ Birth Date_____ Grade_____

Parent Name_____

Phone: Home_____ Work_____ Cell_____

Emergency Contact_____ Phone_____

Doctor's Name_____ Phone_____

Local Hospital_____ Phone_____

MEDICATION: Name:_____

Dose:_____

INSTRUCTIONS: Give immediately_____

Give only if symptoms of allergic reaction develop_____

PARAMEDICS: Call immediately_____

Call only if symptoms of an allergic reaction develop_____

Should the following symptoms develop after eating, medication would be given, paramedics would be called immediately, followed by a call to the parent.

Swelling of lips, tongue, and throat. Hives. Difficulty breathing

HISTORY: Specific foods child is allergic to:_____

_____

Commercially prepared products (store bought) containing this food:_____

_____

Type of reaction experienced:_____

_____

Date of last reaction and necessary treatment:_____

_____

Please complete, sign, and return by:_____

Thank you for your cooperation,

Parent/Guardian Signature_____ **Date**_____

Doctor Signature_____ Date_____

School Nurse Signature_____ Date_____

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ASTHMA CARE PLAN

Student's Name_____ Birth Date_____ Grade_____

Parent Name_____

Phone: Home_____ Work_____ Cell_____

Doctor's Name (for asthma)_____ Phone(_____)_____

Local Hospital_____ Phone(_____)_____

How long has your child had asthma?_____

How severe is your child's asthma? (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

What are your child's usual symptoms?_____

What triggers your child's asthma? (Check all that apply) Allergies_____ Dust_____

Exercise_____ Foods_____ Infections_____ Medications_____ Other (name)_____

What medication(s) does your child take? Indicate if daily or just if needed.

Name of Medication	**Dose**	**How often**

Do you feel your child understands his/her asthma and uses the prescribed medication appropriately? Yes_____ No_____ Explain (if no)_____

Can your child self-administer his/her inhaler without supervision? Yes_____ No_____

What is your child's normal peak flow reading?_____

What do you do for peak flow readings in the:

Yellow Zone (50-80% of normal)_____

Red Zone (below 50%)_____

What action do you take at home to relieve an asthma attack?_____

Parent/Guardian Signature_____ **Date**_____

Doctor Signature_____ Date_____

School Nurse Signature_____ Date_____