KAUFMAN ISD
LIFE THREATENING ALLERGIES AND ASTHMA- STUDENT INFORMATION SHEET

Name:_____ DOB _____ Date: _____

School: _____ Teacher: _____ Grade: ____

Parent(s) Name (s): _____ Home Phone: _____

Doctor's Name: _____Doctor's Phone: _____

List and describe know allergies or suspected reactions to:

Medications/drugs_____

Foods/plants/others _____

Insects _____

Does he/she have allergies and/or asthma diagnosed by a doctor: _____ If yes, at what age? _____

Do you have a prescribed management plan? _____ If yes, please include a copy

Has your child ever been hospitalized with an allergic reaction and/or asthma? _____ Seen in the ER with an allergic reaction and/or asthma? _____

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, if known?

_____

_____

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

_____

_____

Usual Daily Medication (name, dose, times):

_____

_____

Medications given frequently, but not daily?

_____

Describe side effects from medications?

_____

Does he/she know how to administer own medications?

_____