LACTOSE INTOLERANCE CARE PLAN

Name of student:_____ D.O.B._____

Grade:_____

Is your child diagnosed with lactose intolerance? Yes_____ No_____
If yes, when was he/she diagnosed? _____

Please list the signs and symptoms your child experiences when he/she has milk products._____
_____
_____
_____
If your child experiences any of these symptoms, the following action should be taken: _____
_____
_____
_____
Please indicate any medication your child takes for lactose intolerance._____
_____
_____
_____
Will your child need medication at school? _____ If yes, MD order required.

Please list any dairy products, if any, that your child can have at school._____
_____
_____

I give permission for the school nurse to inform appropriate school personnel of this information.

Parent/Guardian signature _____Date_____

Phone # Home _____Work _____Cell_____

Emergency contact_____ Phone_____

Physician's name _____ Phone_____

School Nurse/Date _____