

**MIDDLEBORO PUBLIC SCHOOLS
HEALTH SERVICES**

Provide picture

LACTOSE INTOLERANCE CARE PLAN

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

Grade: _____ Homeroom Teacher and room #: _____

Is your child diagnosed with lactose intolerance? Yes _____ No _____

If yes, when was he/she diagnosed? _____

Will your child need lactaid milk at school? _____ If yes, MD note required with diagnosis.

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 _____ School Nurse _____