GILL ELEMENTARY SCHOOL

48 Boyle Rd.
Gill, MA 01354
Phone: (413) 863-3255

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.________

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If your child experiences any of these symptoms, the following action should be taken: __________

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Please indicate any medication your child takes for lactose intolerance.______________________

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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.______________________

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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_____________________________