

**Congregation B'nai Torah Hebrew School
Allergy Care Plan**

Student's Name _____ Date of Birth _____

Parent's Name _____ Phone _____

Physician's Name _____ Phone _____

1. List triggers that cause an allergic reaction. (i.e. foods, environmental, Bee sting)

2. Briefly describe your child's allergic symptoms.

3. How do you treat an allergic episode once it has started?

_____ antihistamine _____ epi-pen _____ other

Briefly describe _____

4. Does your child experience any side effects from this medication/treatment?

Briefly describe _____

5. Does your child understand his/her allergy management?

_____ Yes _____ No

6. Approximately how frequently does your child have an allergic episode?

7. Please outline the treatment plan for your child if he/she has an allergic reaction at Hebrew School.

Parent Signature _____ Date _____

Hebrew School Director Signature

_____ Date _____

Teacher/Class _____