

Emergency Health Information and Medical Plan

All Families Need to Complete Annually

PART 1 - Parent or Guardian to Complete.

| | | | | |
|----------------------|-------|--------|--------|-----|
| Student's Name: Last | First | Middle | Gender | DOB |
|----------------------|-------|--------|--------|-----|

My child has a medical condition that may affect his or her school day NO YES (if YES, please complete Part 2)

Parent/Guardian's Name (please print)

Parent/Guardian's Signature

Date

PART 2 – Complete all boxes that apply to your child.

ALLERGIES

Allergy type:

- Food List food(s) _____
 Medication List medicine(s) _____
 Bee sting _____
 Other (list) _____

Reactions:

- Coughing Hives Rash
 Difficulty breathing Local Swelling Wheezing
 Generalized swelling Nausea Other _____

Currently prescribed treatments to be used IN SCHOOL

- Oral antihistamine (Benedryl, etc.) EpiPen Other _____

ASTHMA

Triggers: Exercise Environmental Other (list) _____

Physical Restrictions: None Self-limits Other _____

Symptoms or reactions:

- Chest tightness/discomfort/pain Difficulty breathing Throat itch/tightness/soreness
 Coughing Hoarseness Wheezing
 Other _____

Currently prescribed treatments to be used IN SCHOOL

- Inhalers Oral antihistamines Oral steroids
 Nebulizer Oral bronchodilator Peak flow monitoring

Date of last hospitalization related to asthma _____

DIABETES

Currently prescribed treatments to be used IN SCHOOL

- Insulin Syringe Pen Pump
 Blood sugar testing
 Glucagon
 Oral medication(s) List medication(s) _____

SEIZURE DISORDER

Type of seizure:

- Absence (staring/unresponsive) Complex partial Generalized tonic-clonic (grand mal/convulsive)
 Other (explain) _____

Physical restrictions: NO YES

