MEDICAL INFORMATION & EMERGENCY CARE PLAN 2020-2021

Student's Name _____ Grade _____ _____
Sex: M or F DOB _____ School _____
Parent/Guardian Name _____ Phone # (Home) _____ (Work) _____
Parent/Guardian Name _____ Phone # (Home) _____ (Work) _____
Other (Relationship) _____ Phone # (Home) _____ (Work) _____
Physician's Name _____ Office Phone # _____
Hospital of Choice _____

PLEASE CHECK ALL HEALTH CONCERNS THAT APPLY TO YOUR CHILD:

___ ASTHMA ___ DIABETES ___ SEIZURES ___ BEE STING ALLERGY ___ FOOD ALLERGY
___ LATEX ALLERGY ___ ADD/ADHD ___ OTHER _____
___ NO HEALTH CONCERNS

Please COMPLETE ONLY the sections that apply to your child:

ASTHMA

Medications at this time? Yes No Self-Administered? Yes No
Medication_____ Dosage_____ Times Given_____
Medication_____ Dosage_____ Times Given_____

Any restrictions/limitations due to the asthma?_____
Procedure to follow when your child has an asthma attack:_____
_____
Approximately how often does your child have an acute episode?_____
Does your child understand asthma and how to manage it? Yes No

DIABETES

Medications at this time? Yes No Self-Administered? Yes No Insulin Pump? Yes No
Medication_____ Dosage_____ Times Given_____
Medication_____ Dosage_____ Times Given_____

How long has your child been diabetic?_____ Currently under control? Yes No
Does your child understand diabetes/its management? Yes No Does your child recognize symptoms? Yes No
What symptoms does your child experience when becoming hypoglycemic (low blood sugar)?_____
_____
What form of glucose will be provided for a hypoglycemic reaction?_____
Are snacks required during the school day? Yes No Please specify type of snacks and time to be given:_____
_____
Procedure to follow when your child has an insulin reaction:_____
_____

SEIZURE

Medications at this time? Yes No
Medication_____ Dosage_____ Times Given_____
Medication_____ Dosage_____ Times Given_____
When was the last seizure? _____ Describe the type of seizure:_____
Any restrictions/limitations due to the seizures?_____
Procedure to follow when your child has a seizure:_____
_____

OVER….SIGNATURE REQUIRED ON REVERSE SIDE

BEE STING ALLERGY

Will your child have an Epi-Pen at school? Yes No
When was the last reaction? _____ What medical treatment was provided and by whom?_____
_____
Describe the signs/symptoms of the reaction?_____
Procedure to follow when your child has a reaction:_____
_____

FOOD ALLERGY

What food(s) is your child allergic to?_____
What symptoms does your child exhibit when they are having a reaction?_____
Does he/she react to: (Circle all that apply)
Ingestion Touch Smell
Does your child understand his/her food allergy and what he/she needs to do to manage it? Yes No
Does your child have an Epi-Pen? Yes No
Does your child know how and when to use the Epi-Pen? Yes No
Medications at this time? Yes No
Medication_____ Dosage_____ Times Given_____
Procedure to follow when your child has a reaction:_____
_____

LATEX ALLERGY

What symptoms does your child exhibit when they are exposed to latex?_____
When was the last reaction? _____ What medical treatment was provided and by whom?_____
_____
Procedure to follow when your child is exposed to latex:_____
_____

ADD/ADHD

When was your child diagnosed with ADD or ADHD? _____
Medications at this time? Yes No
Medication_____ Dosage_____ Times Given_____

OTHER HEALTH CONCERNS

List any other health concerns/diagnoses your child has:_____
When was he/she diagnosed?_____ Does your child understand the diagnosis? Yes No
Medications at this time? Yes No
Medication_____ Dosage_____ Times Given_____
Medication_____ Dosage_____ Times Given_____
List any restrictions/limitations related to the diagnosis:_____
_____

IN ORDER TO MEET THE HEALTH AND EDUCATIONAL NEEDS OF THE STUDENT, I UNDERSTAND THAT THIS INFORMATION MAY BE SHARED WITH MEMBERS OF THE EDUCATIONAL TEAM. THIS WILL BE DONE ON A "NEED TO KNOW" BASIS, IN A CONFIDENTIAL MANNER.

Parent/Guardian Signature:_____ Date:_____