

MEDICAL INFORMATION & EMERGENCY CARE PLAN 2019-2020

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: _____