

**MEDICAL INFORMATION & EMERGENCY CARE PLAN 2017-2018**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ School Yr \_\_\_\_\_  
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: \_\_\_\_\_