2019/2020 Student Medical Alert Update

Student Name: _____ _____ _____

Last First MI Date of Birth Grade/Teacher

Please complete this form and sign below. Student health information may be shared with school personnel in written, oral and electronic format on a need-to-know basis and as necessary to safeguard your child's health. **Please provide the health room with any updates.**

- ❑ **No physical health concerns**
- ❑ **No medications taken at school**

Allergies list allergen & reaction (Physician-confirmed)

- ❑ Environmental _____
- ❑ Food _____
- ❑ Insect _____
- ❑ Drug _____
- ❑ Other _____
- ❑ Epi-Pen prescribed
- ❑ Needs ALLERGY medication at school_____
- ❑ No ALLERGY medication needed at school

Asthma (Physician-confirmed)

- ❑ Needs ASTHMA medication at school_____
- ❑ Diagnosed, but no ASTHMA medication needed at school

ADD/ADHD

- ❑ Needs ADD/ADHD medication at school _____
- ❑ Takes ADD/ADHD medication at home only __
- ❑ Diagnosed, but not taking medication

Cardiovascular Condition

- ❑ _____

Congenital Condition

- ❑ _____

Diabetes

- ❑ Diagnosed ___/___/____
- ❑ Insulin dependent
- ❑ Non- insulin dependent

Gastro-Intestinal Condition

- ❑ _____

Mental Health Condition

- ❑ Anxiety
- ❑ Depression
- ❑ Autism
- ❑ Asperger's Syndrome
- ❑ Other _____

Migraine Headaches

- ❑ Needs MIGRAINE medication at school _____
- ❑ Diagnosed, but no need for MIGRAINE medication at school

Hearing

- ❑ Wears hearing aid(s)_____
- ❑ Diagnosed hearing loss at age_____

Renal (Urinary) Condition

- ❑ _____

Seizures/Neurological Condition

- ❑ Needs SEIZURE medication at school _____
- ❑ Takes SEIZURE medication at home _____
- ❑ History of seizures, but not presently medicated Date last seizure occurred ___/___/____
- ❑ Other neurological condition_____ _____

Vision

- ❑ Corrected with prescription lenses
- ❑ Other concern _____

Other

- ❑ Other health concern that may affect school performance/attendance_____ _____
- ❑ Medication your child needs at school not already listed _____
- ❑ Physical restrictions _____ _____

NOTE: If medication is needed, parent and health care provider must complete an Authorization for Administration of Medication at School form before medication can be given at school. Students 12 years and older may carry and self-administer medications according to provisions of BP 5432 Medication at School. Please contact school nurse for additional information.

Student Treatment and Release Authorization: *I understand that in the event of an accident or illness, every effort will be made to contact my child's parent/guardian. If the parent/guardian cannot be reached, I authorize and direct school authorities to obtain emergency care for my child. Should the illness or injury not be an emergency and the parent/guardian cannot be reached, I authorize school staff to release my child to the alternate contact person I have designated.*

Parent/Guardian Signature _____ **Date** _____