Community Education & Recreation Department
A Division of Mankato Area Public Schools

INDIVIDUAL HEALTH CARE/EMERGENCY PLAN FOR CHILD WITH A MEDICAL CONDITION

TO BE RENEWED EACH PROGRAM SESSION

(If you need assistance completing this form, contact the Program Coordinator)

Child's Name: _____ Birth Date: _____

Program Site _____ Grade_____ Session _____

Primary Care Provider: _____ Clinic:_____ Phone #_____

DIAGNOSIS: _____

☐ **This diagnosis is no longer a concern. Parent/Guardian Signature: _____ Date:_____**

(IF "NO" IS CHECKED, DO NOT FILL OUT THE REMAINDER OF THE FORM, BUT SIGN AND RETURN IT TO YOUR CHILD'S PROGRAM SITE .)

1) Could this condition be life threatening? Yes ☐ No ☐

2) What signs and/or symptoms of your child's condition should we be aware of?

_____

_____

3) Does your child recognize these signs and symptoms? Yes ☐ No ☐

4) List any known triggers (things that make symptoms worse).____

5) Are there any special considerations or precautions regarding program activities and field trips. Yes ☐ No ☐
If yes, please explain:_____

_____

6) Will your child need any treatment or medications during CER program related to this condition? Yes ☐ No ☐
If yes, please explain: _____
If medication is needed at school, please complete "Consent Form For Administration of Medication"

7) What is an emergency for your child and what should be done?_____

_____

Standard Emergency Plan is to call 911 and notify parent/guardian.

Emergency Contacts

Name: _____ Relationship: _____ Daytime Phone: _____ Cell: _____

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PARENT/GUARDIAN AUTHORIZATION

1. I understand that this plan may be shared with all CER staff working directly with my child.
2. I will contact the CER program coordinator/supervisor if a change in the current plan is indicated.
3. I authorize the CER program coordinator/designee and health care provider to exchange information related to my child's health plan.

Parent/Guardian Signature: _____ Date_____