Health Care Alert

West Bloomfield School District
Educating Students to be their Best IN and FOR the World

This form is to be completed for ALL students prior to the start of each school year ● Update if changes in health status occur

School Year: _____

Student Name	Date of Birth	Age	Grade

Check One: ☐ My Child Has NO Chronic Health Concerns

☐ My Child Has A Chronic Health Condition – *Please Complete Below*

Listed In Alphabetical Order ● Check All That Apply
● Emergency Action Plans &/or Instructions for Daily Management of a Chronic Health Condition Should Be Provided As An Attachment ●

Have there been changes from last school year? ____Yes ____No	
☐ **Allergy**	____Animal(s) ____Food(s) ____Latex ____Medication ____Seasonal ____Stinging Insect (i.e. bee, wasp) *List known allergens* _____ ____History of Anaphylaxis ____Self-carries epinephrine auto-injector* ____Self-administers epinephrine auto-injector *Location of personal epinephrine auto-injectors: ____Backpack ____Purse Other *(Specify)* _____
☐ **Asthma**	____Student self carries rescue inhaler ____Student self administers rescue inhaler ____Exercise Induced Known Triggers *(Specify)* _____
☐ **Diabetes**	____Type I ____Type II ____Insulin Dependent ____Non-Insulin Dependent *Additional Information*: _____
☐ **Emotional or Mental Health Concern**	____ADHD ____Anxiety ____Depression *Other - Describe:* _____
☐ **Seizures**	*Type of seizures:* _____ *Frequency of seizures*: _____
☐ **Other Medical Condition**	Describe: _____

** Per Michigan law and board policy, an emergency action plan & permission signed by both a licensed physician and parent is required for a student to self carry/self-administer emergency medications at school.*

Rev 8/2021