



2020-2021 Grade 6-12 QUINCY SCHOOL DISTRICT NURSE ALERT FORM

Nurse initial _____

504 _____ ECP _____

**This form must be completed for each new school year.*

Name: _____ Birthdate: _____ Sex: M/ F
Last First MI (circle)

School: _____ Grade: _____ Date: _____

Doctor: _____ Clinic: _____

Yes, my child has a life-threatening health condition - Please complete Section 1 and 2

No, my child does not have a life-threatening health condition - Please skip to Section 2

Section 1 – LIFE-THREATENING HEALTH CONDITIONS

- Asthma and requires rescue inhaler at school;** has permission to self-carry yes no
 What triggers the asthma: Exercise Illness Allergies Other: _____
- Anaphylaxis (Life-Threatening Allergy) and requiring emergency medication:** EpiPen: has permission to self-carry yes no
 What causes the allergic reaction? : Bee sting Food: _____ Other: _____
- Diabetes:** Age of diagnosis: _____ Type I Type II Uses Insulin Oral Medication
- Seizure disorder:** Type _____ Date of last seizure: _____ Uses seizure medication
- V/P Shunt (in brain) Cardiac arrhythmia or other cardiac problems which require activity restrictions?**
- Hemophilia/Other blood disorder** _____
- Other Life Threatening Health Condition:** _____

Section 2 - NON-LIFE-THREATENING HEALTH CONDITIONS

- Vision** concerns? Glasses Contacts Other: _____
- Hearing** concerns? Wears hearing aids
- History of Concussion(s):** Age(s) _____ Was a doctor seen? _____ Lasting Effects: _____
- Other:** _____

Please list any other significant health concerns that the school nurse should know about (allergies, surgeries, hospitalizations, disorders, mental health disorders such as ADHD, autism, depression, anxiety, etc.)

MEDICATION

Does your child take any medication? No Yes, name of medication: _____

Will medication be needed at school? No *Yes, name of medication: _____

***If your child needs medication at school, a "Medication Authorization" form is required every year before any medication may be given. This form is available from the school office or on the district website at qsd.wednet.edu**

AUTHORIZATION FOR SHARING HEALTH INFORMATION/ACCESSING MEDICAL CARE

As parent/guardian, I agree to notify the school about any significant change in my child's health status. I also understand that this information will be accessible to the following people: School nurses, teachers, specialists, office staff and emergency medical personnel.

If I cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send my child (properly accompanied) for treatment to the hospital or doctor most easily accessible.

Date

Parent or legal guardian signature