2020-2021 Grade Pre K-5
QUINCY SCHOOL DISTRICT
NURSE ALERT FORM

Nurse initial _____

504____ ECP _____

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

Name: _____ Birthdate: _____ Sex: ☐/☐
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**

What triggers the asthma: ☐ Exercise ☐ Illness ☐ Allergies ☐ Other: _____

☐ **Anaphylaxis (Life-Threatening Allergy) and requiring emergency medication:** ☐EpiPen

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 www.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**

02/21/18