MANKATO AREA PUBLIC SCHOOLS
COMMUNITY EDUCATION

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

Child's Name: _____ Birth Date: _____

Program Name/Site: _____ Grade: _____

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)

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 CE program related to this condition? ☐ **Yes** ☐ **No**

   If yes, please explain: _____

   (If medication is needed, 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)

OVER

Child's Name: _____

Emergency Contacts: (*list in order of who to call first*)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PARENT/GUARDIAN AUTHORIZATION

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

Parent/Guardian Signature: **Date:**