



Yearly Alert - Any Medications or Conditions Such As: Asthma, Diabetes, Migraines, Allergies, etc.

January 2026

Dear Parent(s)/Guardian(s):

If your daughter requires medication during school hours, prescribed or over-the-counter, it must be brought to school and kept in the Nurse's Office and administered by the school nurse. This includes medication for headaches, menstrual cramps or any other medical condition.

Medication Policy

If sending medication to school, the following procedures must be followed:

- **School Medication Authorization Form** must be completed by a licensed prescriber and parent/guardian whether **for prescription as well as non-prescription medications** and returned to the school nurse. **This form is completed annually.**
- **Prescription medication** brought to the Nurse's Office in an original pharmacy container with a pharmacy label. Your pharmacy should be able to supply an extra labeled container for school. Include student's name, date of birth, and year of graduation affixed to the container.
- **Non-prescription medication** brought to the Nurse's Office in the original package with the student's name, date of birth, and year of graduation affixed to the container.
- **If medication dose changes or is discontinued**, parents must notify the school nurse in writing with confirmation from the licensed prescriber.

No medication will be given unless these guidelines are followed. The intent of these guidelines is to provide safe administration of medications.

Use of Inhalers

Students diagnosed with Asthma should always carry their inhaler. A completed **School Medication Authorization Form** should be sent to school **annually** for placement with her medical records. If desired, an extra inhaler may be kept locked up in the Nurse's Office.

According to the Illinois Public Act 099-0843, schools are required to ask parents/guardians of students with Asthma to submit a current Asthma Action Plan. If your daughter has Asthma, please have your physician complete the [Asthma Action Plan Form](#). It will be kept on file in the Nurse's Office. This Asthma action plan needs to be updated yearly.

Diabetes

According to the Illinois Public Act 96-1485, The Care of Students with Diabetes Act, if your daughter has Diabetes and requires assistance with managing this condition while at school and school functions, a Diabetes Care Plan must be submitted to the school nurse. Please contact your daughter's physician to develop the Diabetes care plan.

Once the Diabetes care plan is on file with the school nurse, parents/guardians are responsible for and must:

- Inform the school nurse of any change which needs to be made to the Diabetes Care Plan on file with the school for their daughter.
- Inform the school in a timely manner of any changes to their emergency contact numbers or contact numbers of healthcare providers.
- Sign the Diabetes Care Plan.
- Grant consent for and authorize the school nurse to communicate directly with the healthcare provider whose instructions are included in the Diabetes Care Plan.

Other Action Plans

[Allergy Action Plan](#)

[Seizure Action Plan](#)

Keeping extra supplies/juices/snacks in the Nurse's Office labeled with the student's name, date of birth, and year of graduation is highly recommended.

Questions or concerns? Please contact our school nurse at:

Phone: 773-881-6524 - **Email: healthforms@mothermcauley.org** - **Fax: 773-881-6624**

Last _____ First _____ Middle _____	Birth Date Month/Day/Year _____	Sex	School	Grade Level/ ID
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HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes	No	List:	MEDICATION (Prescribed or taken on a regular basis.)	Yes	No	List:
Diagnosis of asthma?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Birth defects?	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Developmental delay?	Yes	No		Serious injury or illness?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Diabetes?	Yes	No		TB disease (past or present)?	Yes*	No	
Head injury/Concussion/Passed out?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Seizures? What are they like?	Yes	No		Alcohol/Drug use?	Yes	No	
Heart problem/Shortness of breath?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____			
Dizziness or chest pain with exercise?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.			
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Parent/Guardian			
Ear/Hearing problems?	Yes	No		Signature			Date
Bone/Joint problem/injury/scoliosis?	Yes	No					

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if <2-3 years old	HEIGHT	WEIGHT	BMI	BMI PERCENTILE	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>					

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes No **Blood Test Indicated?** Yes No **Blood Test Date** _____ **Result** _____

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed Test performed **Skin Test: Date Read** _____ **Result: Positive** **Negative** mm _____
Blood Test: Date Reported _____ **Result: Positive** **Negative** Value _____

LAB TESTS (Recommended)	Date	Results	Date	Results
Hemoglobin or Hematocrit				Sickle Cell (when indicated)
Urinalysis				Developmental Screening Tool

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears		Screening Result:	Gastrointestinal	
Eyes		Screening Result:	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)			Other	

NEEDS/MODIFICATIONS required in the school setting _____ **DIETARY** Needs/Restrictions _____

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup _____

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
 If you would like to discuss this student's health with school or school health personnel, check title: Nurse Teacher Counselor Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
 Yes No If yes, please describe. _____

On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes No Modified **INTERSCHOLASTIC SPORTS** Yes No Modified

Print Name _____	(MD,DO, APN, PA) Signature _____	Date _____
Address _____		Phone _____

INSTRUCTIONS FOR COMPLETING

ILLINOIS CERTIFICATE OF RELIGIOUS EXEMPTION TO REQUIRED IMMUNIZATIONS AND/OR EXAMINATIONS FORM

Who may use the Certificate of Religious Exemption to Required Immunizations and/or Examinations Form:

- Parents or legal guardians who are requesting a religious exemption to immunizations or examinations **must** use this form for students entering kindergarten, sixth, or ninth grades.
- A separate form must be used for **each child** with a religious exemption enrolled to enter any public, charter, private or parochial preschool, kindergarten, elementary or secondary school.
- This form may not be used for exemptions from immunizations and/or examination for personal or philosophical reasons. Illinois law does not allow for such exemptions. (See excerpts below from Public Act 099-0249 enacted August 3, 2015 at page bottom.)

When use of this form becomes required: October 16, 2015

How to complete the Certificate of Religious Exemption to Required Immunizations and/or Examinations Form:

- Complete the Parent/Guardian sections, which include key information about the student and the school the student will be entering, and the immunizations or examinations for which religious exemption is being requested. Provide a statement of religious belief(s) **for each vaccination/examination requested**.
- The form must be signed by the child's parent or legal guardian **AND** the child's health care provider* **responsible for performing the child's health examination**.
- Submit the completed form to local school authority on or before October 15th of the school year, or by an earlier enrollment date established by a school district.

Religious Exemption from Immunizations and/or Examination Form Process:

- The local school authority is responsible for determining whether the information supplied on the Certificate of Religious Exemption to Required Immunizations and/or Examinations Form constitutes a valid religious objection.
- The local school authority shall inform the parent or legal guardian, at the time that the exemption is presented, of exclusion procedures, should there be an outbreak of one or more diseases from which the student is not protected, in accordance with the Illinois Department of Public Health (IDPH) rules, Control of Communicable Diseases Code (77 Ill. Adm. Code 690).
- Exempting a child from health, dental, or eye examination does not exempt the child from participation in the program of physical education training provided in Section 27-5 through 27-7 of the Illinois School Code [105 ILCS 5/27-5 through 105 ILCS 5/27-7]. A separate request for exemption from physical education, if desired, would need to be presented.

Excerpt from Public Act 099-0249 enacted August 3, 2015:

Children of parents or legal guardians who object to health, dental, or eye examinations or any part thereof, or to immunizations or to vision and hearing screening tests on religious grounds shall not be required to undergo the examinations or immunizations if the parents or legal guardians present to the appropriate local school authority a signed Certificate of Religious Exemption detailing the grounds for objection and the specific immunizations and/or examinations to which they object. The grounds for objection must set forth the specific religious belief(s) that conflict with the examination, immunization, or other medical intervention. The certificate will be signed by the parent or legal guardian to confirm their awareness of the school's exclusion policies in the case of a vaccine preventable disease outbreak or exposure. The certificate must also be signed by the child's health care provider responsible for performing the child's examination for entry into kindergarten, sixth or ninth grade. This signature affirms that the provider educated the parent or legal guardian about the benefits of immunization and the health risks to the student and to the community from the communicable diseases for which immunization is required in Illinois.

The religious objection provided need not be directed by the tenets of an established religious organization. However, general philosophical or moral reluctance to allow physical examinations, eye examinations, immunizations, vision and hearing screening or dental examinations will not provide a sufficient basis for an exception to statutory requirements. The local school authority is responsible for determining if the content of the Certificate of Religious Exemption constitutes a valid religious objection.

The local school authority shall inform the parent or legal guardian of exclusion procedures in accordance with IDPH's rules, Control of Communicable Diseases Code (77 Ill. Adm. Code 690) at the time the objection is presented.

**ILLINOIS CERTIFICATE OF RELIGIOUS EXEMPTION
TO REQUIRED IMMUNIZATIONS AND/OR EXAMINATIONS FORM**

PARENT OR LEGAL GUARDIAN - COMPLETE THIS SECTION

Note: This form is required for all students entering kindergarten, sixth or ninth grades when parent(s) or legal guardian(s) is requesting a religious exemption on or after October 16, 2015. This form also must be submitted to request religious exemption for any student enrolling to enter any public, charter, private or parochial preschool, kindergarten, elementary or secondary school on or after October 16, 2015.

This form may NOT be used for personal or philosophical reasons. Illinois law does not allow for such exemptions.

Student Name:(last, first, middle) _____	Student Date of Birth: Month Day Year ____/____/____	School Name: _____	Grade: _____
Parent/Guardian Name: _____ _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	City: _____	Exemption requested for (mark all that apply): <input type="checkbox"/> Hepatitis B <input type="checkbox"/> DTaP <input type="checkbox"/> Polio <input type="checkbox"/> Hib <input type="checkbox"/> Pneumococcal <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Td/Tdap <input type="checkbox"/> Meningococcal <input type="checkbox"/> Health Exam <input type="checkbox"/> Eye Exam <input type="checkbox"/> Dental Exam <input type="checkbox"/> Vision/Hearing Tests <input type="checkbox"/> Other (indicate below)
Address: _____ _____ _____	Telephone Number(s): _____ _____		

To receive an exemption to vaccination/examination, a parent or legal guardian must provide a statement detailing the religious beliefs that prevent the child from receiving each required school vaccinations/examination being requested. In the space provided below, **state each vaccination or examination exemption requested and state the religious grounds for each request.** If additional space is needed, attach additional page(s).

Religious Exemption Notice:

No student is required to have an immunization/examination that is contrary to the religious beliefs of his/her parent or legal guardian. However, not following vaccination recommendations may endanger the health or life of the unvaccinated student, others with whom they come in contact, and individuals in the community. In a disease outbreak, or after exposure to any of the diseases for which immunization is required, schools may exclude children who are not vaccinated in order to protect all students. I have read the Religious Exemption Notice (above) and have provided requested information for each vaccination/examination being requested for religious exemption.

Signature of parent or legal guardian (required) _____

Date _____

HEALTH CARE PROVIDER* – COMPLETE THIS SECTION

Provision of information: I have provided the parent or legal guardian of the student named above, with information regarding **1) the required examinations, 2) the benefits of immunization, and 3) the health risks to the student and to the community from the communicable diseases for which immunization is required in Illinois.** I understand that my signature only reflects that this information was provided; I am not affirming the parent or legal guardian's religious beliefs regarding any examination, immunization or immunizing agent.

Signature of health care provider* _____

Health Care Provider Name: _____

Address: _____

Date: _____
(Must be within 1 year prior to school entry)

Telephone #: _____

*Health care provider responsible for performing child's health examination includes physicians licensed to practice medicine in all of its branches, advanced practice nurses, or physician assistants.



MOTHER MCAULEY

Liberal Arts High School

3737 W. 99th Street, Chicago, IL 60655

2026-2027

School Medication Authorization Form

This form is to be completed by a licensed prescriber and parent/guardian. All prescription and non-prescription medications must be properly labeled with the student's name, date of birth, and year of graduation. These medications are kept in the Nurse's office. This form must be updated yearly.

Student Name: _____ (Print)

Date of Birth: _____ Year of Graduation: _____

Medications to be given during school hours, if needed: _____

Dosage: _____ Route: _____

Time of Administration: _____

Diagnosis Requiring Medication: _____

Possible Side Effects: _____

Other Medications student is receiving when not in school: _____

Physician's Signature: _____ Date: _____

Physician's Name Printed: _____

Physician's Phone Number: _____

PARENT/GUARDIAN AUTHORIZATION:

I hereby authorize the School Nurse at Mother McAuley High School to administer the above medication(s) during school hours. Per 105 ILCS 5/22-30(c), the school and school personnel incur no liability for injuries occurring when administering medication(s), asthma medication, an epinephrine auto-injector, or an opioid antagonist.

Parent/Guardian Signature: _____ Date: _____

Cell: () - _____ Work: () - _____

Please contact our school nurse, if you should have any questions:

Phone: 773-881-6524 - Email: healthforms@mothermcauley.org - Fax: 773-881-6624



MOTHER MCAULEY

Liberal Arts High School

3737 W. 99th Street, Chicago, IL 60655

2026-2027 Inhaler/Epipen Policy Statement

Mother McAuley Liberal Arts High School has received your request for self-administration of:

_____ (List medication)

for your child, _____

(Print student's name)

State law requires that we inform the parents/guardians of the student, in writing, that Mother McAuley Liberal Arts High School and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the above named student. Before we can allow your child to self-administer the medication, we must ask that you sign and return this document.

The permission for self-administration of medication is effective for the school year for which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements outlined above. A student with asthma may possess and use her medication during school hours, at a school-sponsored activity (dance, game, etc.), or before or after normal school hours. We recommend that you provide an additional dose of the medication to be kept at school in the event that your child forgets or loses her medication.

Parent/Guardian Permission Statement

I have read the above policy and acknowledge that Mother McAuley Liberal Arts High School and its employees and agents are to incur no liability and I indemnify and hold harmless Mother McAuley Liberal Arts High School and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medicine by the above named student.

Parent/Guardian Signature: _____

Date: _____

Please contact our school nurse, if you should have any questions:

Phone: 773-881-6524 - **Email:** healthforms@mothermcauley.org - **Fax:** 773-881-6624

Illinois Department of Public Health

Asthma Action Plan

Patient Name _____ Weight _____ Date of Birth _____ Peak Flow _____

Primary Care Provider Name _____ Phone _____

Primary Care Clinic Name _____

Symptom Triggers _____

Asthma Severity

Green Zone "Go! All Clear!"



- Breathing is easy
- Can play, work and sleep without asthma symptoms

Peak Flow Range

(80% - 100% of personal best)

The **GREEN ZONE** means take the following medicine(s) every day.

Controller Medicine(s)

Dose

Spacer Used _____

Take the following medicine if needed 10-20 minutes before sports, exercise or any other strenuous activity.

Yellow Zone "Caution..."



- Breathing is easy
- Cough or wheeze
- Chest is tight

Peak Flow Range

(50% - 80% of personal best)

The **YELLOW ZONE** means keep taking your GREEN ZONE controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse.

Reliever Medicine(s)

Dose

If beginning cold symptoms, call your doctor before starting oral steroids.

Use Quick Reliever (two - four puffs) every 20 minutes for up to one hour or use nebulizer once. If your symptoms are not better or you do not return to the GREEN ZONE after one hour, follow RED ZONE instructions. If you are in the YELLOW ZONE for more than 12-24 hours, call your provider. If your breathing symptoms get worse, call your provider.

Red Zone "STOP! Medical Alert!"



- Medicine is not helping
- Nose opens wide to breathe
- Breathing is hard and fast
- Trouble Walking
- Trouble Talking
- Ribs show

Peak Flow Range

(Below 50% of personal best)

The **RED ZONE** means start taking your RED ZONE medicine(s) and call your doctor NOW! Take these medicines until you talk with your doctor. If your symptoms do not get better and you can't reach your doctor, go to a **hospital emergency department or call 911 immediately.**

Reliever Medicine(s)

Dose

For more information on asthma, please visit the National Heart, Lung and Blood Institute at www.nhlbi.nih.gov, the U.S. Centers for Disease Control and Prevention at www.cdc.gov or the U.S. Environmental Protection Agency at www.epa.gov.

If you would like more information on Illinois' asthma program, please contact the Illinois Department of Public Health at 217-782-3300.

ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Child's
Photograph

NAME: _____ D.O.B: ____ / ____ / ____

TEACHER: _____ GRADE: _____

ALLERGY TO: _____

Asthma: Yes (higher risk for a severe reaction) No

Weight: _____ lbs

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin Monitoring (see below)
- Additional medications:
- Antihistamine
- Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis) → Use Epinephrine.

When in doubt, use epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

- If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.
- If checked, give epinephrine before symptoms if the allergen was definitely eaten.

MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): _____

ANTI-HISTAMINE (BRAND AND DOSE): _____

Other (e.g., inhaler-bronchodilator if asthma): _____

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

- Student may self-carry epinephrine
- Student may self-administer epinephrine

CONTACTS: Call 911 Rescue squad: (____) _____

Parent/Guardian: _____ Ph: (____) _____

Name/Relationship: _____ Ph: (____) _____

Name/Relationship: _____ Ph: (____) _____

Licensed Healthcare Provider Signature: _____ Phone: _____ Date: _____
(Required)

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian Signature: _____ Date: _____

DOCUMENTATION

- Gather accurate information about the reaction, including who assisted in the medical intervention and who witnessed the event.
- Save food eaten before the reaction, place in a plastic zipper bag (e.g., Ziploc bag) and freeze for analysis.
- If food was provided by school cafeteria, review food labels with head cook.
- Follow-up:
 - Review facts about the reaction with the student and parents and provide the facts to those who witnessed the reaction or are involved with the student, on a need-to-know basis. Explanations will be age-appropriate.
 - Amend the Emergency Action Plan (EAP), Individual Health Care Plan (IHCP) and/or 504 Plan as needed.
 - Specify any changes to prevent another reaction.

TRAINED STAFF MEMBERS

Name: _____

Room: _____

Name: _____

Room: _____

Name: _____

Room: _____

LOCATION OF MEDICATION

- Student to carry
- Health Office/Designated Area for Medication
- Other: _____

ADDITIONAL RESOURCES

American Academy of Allergy, Asthma and Immunology (AAAAI)

414.272.6071

<http://www.aaaai.org>

http://www.aaaai.org/patients/resources/fact_sheets/food_allergy.pdf

http://www.aaaai.org/members/allied_health/tool_kit/ppt/

Children's Memorial Hospital

800.543.7362 (800.KIDS DOC®)

<http://www.childrensmemorial.org>

Food Allergy Initiative (FAI)

212.207.1974

<http://www.faiusa.org>

Food Allergy and Anaphylaxis Network (FAAN)

800.929.4040

<http://www.foodallergy.org>

This document is based on input from medical professionals including Physicians, APNs, RNs and certified school nurses. It is meant to be useful for anyone with any level of training in dealing with a food allergy reaction.

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply)

- First aid – **Stay. Safe. Side.**
- Give rescue therapy according to SAP
- Notify emergency contact
- Notify emergency contact at _____
- Call 911 for transport to _____
- Other _____

First aid for any seizure

- STAY** calm, keep calm, **begin timing seizure**
- Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- STAY** until recovered from seizure
- Swipe magnet for VNS
- Write down what happens _____
- Other _____

When to call 911

- Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- Difficulty breathing after seizure
- Serious injury occurs or suspected, seizure in water

When to call your provider first

- Change in seizure type, number or pattern
- Person does not return to usual behavior (i.e., confused for a long period)
- First time seizure that stops on its' own
- Other medical problems or pregnancy need to be checked

When rescue therapy may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

Emergency Department: _____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: VNS RNS DBS Date Implanted _____

Diet Therapy Ketogenic Low Glycemic Modified Atkins Other (describe) _____

Special Instructions: _____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply)

- First aid – **Stay. Safe. Side.**
- Give rescue therapy according to SAP
- Notify emergency contact
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- SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- STAY** until recovered from seizure
- Swipe magnet for VNS
- Write down what happens _____
- Other _____

When to call 911

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When rescue therapy may be needed:

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If seizure (cluster, # or length) _____

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How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

Emergency Department: _____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: VNS RNS DBS Date Implanted _____

Diet Therapy Ketogenic Low Glycemic Modified Atkins Other (describe) _____

Special Instructions: _____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____



Pre-participation Examination



To be completed by athlete or parent prior to examination.

Name _____ School Year _____
Last First Middle

Address _____ City/State _____

Phone No. _____ Birthdate _____ Age _____ Class _____ Student ID No. _____

Parent's Name _____ Phone No. _____

Address _____ City/State _____

HISTORY FORM

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Have you or any family member or relative been diagnosed with cancer?		
52. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	Yes	No
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____



Pre-participation Examination



PHYSICAL EXAMINATION FORM

Name _____

Last _____

First _____

Middle _____

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP / (/)	Pulse	Vision R 20/	L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL		NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic ^c			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/Ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date.

Yes _____ No _____ Limited _____ Examination Date _____

Additional Comments:

Physician's Signature _____ Physician's Name _____

Physician's Assistant Signature* _____ PA's Name _____

Advanced Nurse Practitioner's Signature* _____ ANP's Name _____

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.



PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City		ZIP Code
Name of School:	ZIP Code		Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:	Last Name		First Name	
Student's Race/Ethnicity:				
<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				

To be completed by dentist:

Date of Most Recent Examination: _____ (Check all services provided at this examination date)
 Dental Cleaning Sealant Fluoride treatment Restoration of teeth due to caries

Oral Health Status (check all that apply)

- Yes No **Dental Sealants Present on Permanent Molars**
- Yes No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.
- Yes No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.
- Yes No **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

- Restorative Care** — amalgams, composites, crowns, etc. Appointment Date: _____
- Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date: _____
- Pediatric Dentist Referral Recommended** Treatment Completion Date: _____

Additional comments: _____

Signature of Dentist _____ License #: _____ Date: _____





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