



Medical Care Plan

Student: _____

Parent: _____

Phone: _____

Emergency Contact: _____

Phone: _____

MEDICAL CONDITION(S): _____

If your child's condition is **allergy** related, please provide the following information:

If the allergy is food related, does your child have a reaction only when the food is ingested or when they are around someone eating the food? _____

What are the signs your child is having an allergic reaction?

Does your child have an EpiPen? Yes _____ No _____

If yes, is he/she capable of injecting himself/herself? _____

SCHOOL'S RESPONSE TO ONSET: (Be specific)

If your child's condition is related to **seizure** activity, please provide the following information:

What does his/her seizures look like? _____

Are there noticeable precursors to your child having a seizure? If so, please describe. _____



How long does a typical seizure last? _____

What is the protocol for when a seizure last longer than the typical timeframe? (Be specific)

EMS should be called if the child is still seizing after _____ minutes.

Preferred hospital: _____

If your child's condition is related to **asthma**, please provide the following information:

What triggers your child's asthma? (check all that apply)

Pollen _____ Colds/flu _____ Change in weather _____

Laughing or crying _____ Other _____

What symptoms does your child display? (check all that apply)

Coughing _____ Chest tightness _____ Wheezing _____ Shortness of breath _____

Can your child participate in routine physical/outdoor activities? Yes _____ No _____

With limitations (please list):

Does your child use a quick relief or rescue inhaler? Yes _____ No _____

Does your child use a daily control inhaler? Yes _____ No _____ If yes to either question, please schedule a time to review your child's protocol with staff.

Does your child have any other condition that staff should be aware of? Please describe the condition and staff response necessary to keep your child safe.

Parent Signature: _____ Date: _____