1350-10B FORM – Student Medical Alert

(Parent to Complete)

Student Name: _____ Birthdate: _____

Personal Health Number: _____

Physician: _____ Physician's Phone: _____

Parent/Guardian: _____ Home Phone: _____

Work Phone Number(s): _____

Alternate Emergency Contact: _____ Phone: _____

Parent/Guardian Providing Information: _____ Date: _____

HEALTH CONDITION: _____

DATE OF ONSET OF CONDITION: _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

MEDICATION NEEDED AT SCHOOL: ❒ **No** ❒ **Yes** **(if yes, attach Request for Administration of Medication at School – Form 1350-10A)**

ACTION PLANS (updated yearly)

If your child has Diabetes, Seizures, Anaphylaxis, or severe Asthma, you will need to fill out the appropriate action plan or sign the existing Medical Safety Plan created by the school. Please check the following action plans that apply to your child:

- ❒ Signed Exiting Action Plan
- ❒ Anaphylaxis
- ❒ Diabetes
- ❒ Seizures
- ❒ Asthma

Other: Please Specify _____

Freedom of Information Act Discussed: Date: _____ Signature: _____

ACTION PLAN
DIABETES

Does the student have an insulin pump?

- ❒ Yes
- ❒ No

If the student has a tester, does the student carry their tester with them?

- ❒ Yes
- ❒ No

Does the student have an emergency glucagon injection to be stored at the school?

- ❒ Yes
- ❒ No

Does your child carry snacks, glucose tablets or juice?

- ❒ Yes
- ❒ No

How often does your child have a low blood sugar reaction? _____

Please indicate each of your child's symptoms of low blood sugar :

- ❒ Irritability
- ❒ Headache
- ❒ Tremors
- ❒ Hunger / Nausea
- ❒ Sweating
- ❒ Dizziness
- ❒ Tired / Pale
- ❒ Other (please describe) _____

Treatment for testing low – if student's blood sugar is below _____, please take the following actions:

_____

_____

_____

ACTION PLAN
ANAPHALAXIS

What is the student allergic to? _____

What does your child have an anaphalxis reaction to (needing an EpiPen?) _____

_____

Does the Student carry an EpiPen on them?

- ❒ Yes
- ❒ No

Have you provided a current EpiPen for the school's safety board? (Please note you will need to complete a request for administration of medication form).

- ❒ Yes
- ❒ No

Does the student require any other medication for allergies in addition to an EpiPen?

_____

_____

What are your child's symptoms of an allergic reaction? Check all applicable:

- ❒ Swelling of eyes / lips/ face/ tongue
- ❒ Difficulty breathing/swallowing
- ❒ Cold, clammy, sweaty skin
- ❒ Flushed face or body
- ❒ Changes of voice
- ❒ Other (please describe) _____
- ❒ Fainting or loss of consciousness
- ❒ Vomiting
- ❒ Coughing or choking
- ❒ Stomach cramps, diarrhea

ACTION PLAN

SEIZURES

Medical Condition _____Date of last seizure _____

Type of seizure(s) common to your child _____

Warning symptoms prior to seizure_____

_____

Duration of seizures _____

What happens during a seizure _____

_____

_____

Medication:
Name _____ Dosage _____

Administered _____

Possible side effects of medication(s):_____

_____

ACTION PLAN

ASTHMA

Asthma Triggers – Check all applicable:

- ❒ Chalk Dust
- ❒ Respiratory Infections
- ❒ Change in Temperature
- ❒ Excitement / upset
- ❒ Food
- ❒ Other
- ❒ Animals
- ❒ Pollens
- ❒ Moulds
- ❒ Strong odors / fumes

_____

_____

Does the student carry their inhaler with them?

- ❒ Yes
- ❒ No

Is the student able to administer their inhaler independently?

- ❒ Yes
- ❒ No

Would you like an inhaler to be located in the office on our safety board?

- ❒ Yes
- ❒ No

Has the student been hospitalized for asthma in the past?

- ❒ Yes
- ❒ No

How frequent are the students asthma attacks _____

What symptoms signal an oncoming asthma attack? _____

What type of asthma medication does your child take?_____