

ST. ISIDORE SCHOOL ~ SPECIAL HEALTH NEEDS PLAN 2008-2009
CONFIDENTIAL: FOR SCHOOL PERSONNEL ONLY

Please complete this form if your child has any medical conditions, issues, chronic or acute illnesses, medications, physical limitations, history of serious injuries or previous surgeries that the school should be aware of.

Name: _____ **Grade:** _____ **Teacher:** _____

CURRENT HEALTH ISSUES AND MEDICAL HISTORY:

What is your child's medical condition, health issues, chronic or acute illness, physical limitations or medical history. Please describe anything that school personnel should be aware of:

Is your child currently under care for this condition? Yes No

ALLERGIES AND ASTHMA:

Does your child have any allergies? Yes No

Please list any allergies to food, bee stings, medication or other allergens: _____

Please explain your child's reaction to any of the above listed allergens: _____

Does your child have asthma? Yes No Age of onset: _____

Does your child use an inhaler? Yes No How often? _____

Does your child have an epipen? Yes No

MEDICATIONS:

Does your child take any medications on a regular basis? Yes No

If yes, please list medication(s) and reason for medication(s): _____

PLAN:

Please list any special daily needs other than medication (i.e. blood sugar testing, modifications, etc.): _____

If applicable, please describe how your child's condition is manifested (i.e. symptoms, signs of distress, specific triggers, etc.):

In the event of an emergency, we will call 911 and, if applicable, we will implement the student's Emergency Action Plan. In a non-emergent situation, please explain any steps you would like school personnel to take to assist your child:

Physician's Name: _____ **Phone #:** _____
(signature not required)

Parent's Signature: _____ **Date:** _____

Parent's phone #: _____ Parent's Email: _____