HEALTH EMERGENCY FORM

Page 1 of this document must be reviewed yearly.

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Teacher/Grade

Student Name: ____________________________________ Male Female DOB ____________________

Address: ____ Phone _______________________

Please list any Health Issues or Allergies we should be aware of: ____

____

Medications taken at home: ____

Medications taken at school: ____

In case of emergency or illness, list all numbers where you can be reached:

Parent(s)/Guardian(s) Name	Work Place/Hrs.	Work Phone#	Cell Phone #

In case of an emergency, and the above cannot be reached, I authorize the school district to contact and release the student to the following persons in the order designated.

Name	Relationship	Home Phone#	Work Phone#	Cell Phone #

Daycare Provider: _______________________________________ Phone________________ Cell ________________

Physician: ____ Phone _________________________________

Dentist: ____ Phone _________________________________

Life threatening health information will be shared with building staff members who work with your student. If you do not want to have non-life threatening health information shared with staff members, other than the building administrator(s) and school nurse, please send written documentation to the school nurse.

During normal school hours in life threatening situations, 911 will be called. If severe Asthma or Allergic reaction occurs, 911 will be called, injected Epinephrine will be administered, followed by nebulized Albuterol. Please inform the school nurse in writing if your student has a medical condition that would require this not to be implemented.

____ ________________________
Parent/Guardian Signature (required): Date

Revised: 1/26/2016

Millard Public Schools

Student Asthma/Severe Allergy Information

Page 2 of this document needs to be completed ONLY if your child has asthma or severe allergies.

Student Name: ___________________________________ Male Female DOB ____________________

Address: ____ Phone: _______________________

Parent/Guardian: ____

Physician Treating Asthma: ____ Phone: _______________________

Current status of your child's Asthma (please mark one) Mild Moderate Severe

Does your child use an "as needed" Inhaler Yes No

If yes, Inhaler Name: ____

Does your child require any medication at school for Asthma? Yes No

Does your child use a Peak Flow Meter? Yes No

Students Normal Peak Flow's Green Zone: _______________ Action: Green Zone: _______________

Yellow Zone: ______________ Action: Green Zone: _______________

Red Zone: _______________ Action: Green Zone: _______________

Asthma Medication(s) taken: ____

____

Please identify the things that trigger an asthma episode for your child: _____________________________________

____

Severe Allergy Information
Complete this ONLY if Your Student has SEVERE Allergies

My child has a severe allergic reaction to the following: ____

____

Action taken for mild reaction:____

Action taken for severe reaction: ____

Allergy medication(s) taken at home: ____

Allergy medication(s) taken at school: ____

Comments/Special Instructions: