HEALTH CONDITION ALERT FORM

Program: First Day Attending:

Staff Completing Form:

Physician Name:

Clinic Address:

Telephone Number:

Child Name: DOB:

Address - Home:

Parent/Guardian Name:

Home Phone: Work Phone: Cell Phone:

Parent/Guardian Name:

Home Phone: Work Phone: Cell Phone:

The white copy of this form must be kept with the child during all hours the child is in attendance. A review by parent/guardian(s) and staff should occur at least midway through the program year or when additional information is necessary. The nurse (PNP/RN) and/or teacher will contact parent/guardian for more information.

1. Is your child currently taking any medication? Yes ☐ No ☐ If yes, list medication name & reason for med:
   Will this medication be needed at school? Yes ☐ No ☐ ***If yes, complete "Authorization to Administer Medication" form now.***

2. Check any special medical condition that your child may have: □ **no specific medical condition** (*rest of form not required-please sign below)*

☐ Food Allergies:
- ☐ Milk Allergy
- ☐ Other food(s) (please specify): _____
- ☐ If yes, contact PNP immediately, with parent/guardian contact info.
- ☐ Epi-pen prescribed? ***If yes, complete Authorization to Administer Medication form***.

☐ Non-food allergies – circle: animals, plants, trees, grass, insects, bee stings, other (specify):_____
- ☐ Epi-pen prescribed? ***If yes, complete Authorization to Administer Medication form.***

□ Asthma □ Diabetes □ Epilepsy / seizure disorder □ Cerebral Palsy / motor disorder □ Emotional / behavior disorder (including ADD or ADHD)
□ Gastrointestinal or feeding concerns (including special diet and supplements) □ Any disorder including Cognitively Disabled, LD, or Autism
□ Other condition(s) requiring special care in the classroom: _____

2a. Describe signs or symptoms to watch for:	2b. What causes signs or symptoms to occur:

3. Steps the teachers should follow if symptoms occur: ***If medications are necessary, please attach a signed copy of the "Authorization to Administer Medication" form.***
   a.
   b.
   Program staff who have received special training/instructions to help treat symptoms to be identified on Health Action Plan:

4. When to call parents regarding symptoms or failure to respond to treatment:

5. When to consider that the condition requires emergency medical care or reassessment:

6. Additional information that may be helpful to the teachers/staff:

Parent/Guardian Signature Date

For PNP/HNM use only: Date Reach Dane Health Action Plan signed:
Comments:

Second semester review dates/parent initials: _____