HUHS

Date:_____

STUDENT HEALTH INFORMATION AND PLANS

THIS FORM NEEDS TO BE REDONE EVERY NEW SCHOOL YEAR

Parents: Complete, print, ***sign*** *&* *have* **physician signatures** *if necessary, & return this form to the Health Office or mail to:*

HUHS
Attn: Health Technician
805 Cedar Street
Hartford, WI 53027

or fax: 262-673-8943
HUHS Health Office Phone number: 262-670-3203

Student's Name: Birthday: School Year: Grade:

HEALTH CONDITION(s): ***For asthma, allergies, diabetes or seizures, see the special sections on the back of this form*** ⇨

SYMPTOMS:

SIGNS OF AN EMERGENCY:

Comments_____

***Students given an Epi-Pen, Glucagon, having a seizure (greater than 5-10 minutes) or with significant difficulty breathing will require transport to the nearest medical facility. **Students who staff feels have any other life-threatening emergency; will be transported to the nearest medical facility**.

Attach additional information or instructions as needed relating to specific medical problems to this form.

MEDICATIONS - Prescription medications (including but not limited to Epi-pens, Glucagon and insulin) taken at school need a ***MEDICATION CARD*** obtained from the Health Technician OR online at www.huhs.org, District, Health Services. These must be signed by the student's physician and parent. Over-the-counter medications may be self-administered by the student if the student is responsible and understands what it is for and when to take it. All medication must be provided from home, in the original container, have the student's name on it, dosage and frequency. If your child requires help taking over-the-counter medication(s), please contact the Health Technician for more information.

Required signatures on back turn over please

ASTHMA MANAGEMENT PLAN: **What triggers an asthma episode (check each box that applies) -**

- ☐ Exercise
- ☐ Respiratory infections
- ☐ Change in temperature
- ☐ Animals
- ☐ Food
- ☐ Strong odors or fumes
- ☐ Chalk dust
- ☐ Carpets in the room
- ☐ Pollens
- ☐ Molds

Other Info____

Current Asthma Medications and dose(s)____

****** My child may have a nebulizer treatment with Albuterol 0.083% (Albuterol provided by HUHS), if the Health Technician feels it is medically necessary due to difficulty breathing, wheezing, and/or not having their asrhma inhaler with them:

___ yes ___no **If no**, an ambulance will be called for transport to the nearest medical facility.

SEIZURE MANAGEMENT PLAN

Type of seizures:

What does seizure look like and how long does it usually last?

Names of seizure medication(s) student is taking and doses: ____

ALLERGY MANAGEMENT PLAN

Severe Allergy to:

Nonsevere allergy to:

Benadryl (**provided by parent**) ___ yes ___no Dosage____

Epi-Pen used for this/these allergies? ____yes ____no **(If an Epi-Pen is kept at school - a physician signature is required below)**

*** Epi-Pen administration will require calling an ambulance for transport.

How long ago was last reaction?____________ What happened?____

DIABETES PLAN: Please discuss diabetes plans with Health Technician for further info and forms, (must have Glucagon at school.)

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REQUIRED SIGNATURES:

As the **parent/guardian**, I ask for assistance to be provided to my child in taking the above listed medication(s) at school with the help by staff if necessary. By signing below, I agree and understand some medical information may need to be shared with other HUHS staff members, adult helpers for field trips or emergency responders to keep my child safe at school. I give permission for my child to be transported to the nearest emergency facility if their medical condition warrants it.

Parent/Guardian Signature _________________________________ Date_______________

As the medical professional of the above named student, I ask that assistance be provided to my patient in taking the above listed medication(s) at school by staff if necessary as authorized by the parent/guardian and myself. This includes administration of an Epi-Pen, Glucagon, Albuterol treatment by nebulizer or inhaler, oxygen, topical medications, Diastat, oral medication, or eye/ear drops. Narcan nasal spray may be given in the case of a suspected overdose.

Physician Signature _____________________________________ Date ____________________

*Required for **all prescription** medication taken at school

Health Technician Reviewed____ Date ____________________