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MEDICAL ALERT- Emergency Health Plan

(To be completed & signed by physician/health care provider)

Child Name: _____ Class: _____ Date: _____

Medical Condition requiring possible emergency attention: _____

_____

Symptoms: _____

Physical restriction or adjustments that must be made at school: _____

_____

_____

Is **Rescue/Quick Relief Medication** needed for above symptoms? No Yes
Name _____ Dose _____ When to take _____

This child attends a center preschool program. Does the rescue/quick relief medication need to be kept at school during the hours the child attends? Yes No, explain _____

_____

If the child rides a bus to school, should rescue/quick relief medication be kept on the bus? Yes No, explain:

_____

Specific instructions for staff at school if symptoms occur: _____

_____

_____

Additional Comments: _____

_____

Physician Signature _____ date _____

Physician name, address, phone # (print) _____

_____

Below to be completed by PACT teacher after plan is received from Health Care Provider.

Above plan reviewed with parent on ____/_____/_____ by _____
(Teacher)

Did or does child have any side effects from medication? YES, explain _____ NO

Parent Signature: _____ date _____

Name and RX # of medications listed above which will need to be kept at PACT Site:
Name: _____ RX # _____ Expiration date: ____/____/_____

Name: _____ RX # _____ Expiration date: ____/____/_____
Staff person(s) designated to adm. Medication: _____
Where medication is stored at school: _____
If medication is needed on bus, describe where stored and how transported from bus to school and/or home daily:

_____

CBT gives copy to: ☐ Site Sup. to review, initial, & email to Health Coord. ____
Original: ☐ Teacher for Health & Safety Notebook / Copy: ☐ Bus driver / Copy: ☐ DCFS file H 5/22

LOG for MEDICAL ALERTS/MEDICATION

Child's Name: _____ Class: _____

Log below when child has medical alert symptoms and what was done.
(Review with parent when unusual symptoms or reactions occur and at Parent Teacher Conferences. Parent sign and date when reviewed.)

date	time	Staff name	Describe what happened and what was done, and any medication given If medication given note unusual symptoms, reactions, or changes in behavior that could be due to the medication	Date Parent review	Parent initial

☐ Complete for the year _____ _____
(Teacher Signature) (Date)

When complete for year, teacher signs off & gives to SS to place in DCFS file. SS will notify Health Coordinator by email that medication is complete and HC will take it off 3010 Report. H 5/22