MEDICAL or DIETARY ALERT- Emergency Health Plan HB

For EHS child attending PACT Socialization

Child name ____ HB area ______ Date ___________

Medical or Dietary condition requiring possible emergency attention: ___________________________________

Symptoms: ____

Quick Relief Medication:

Name ________________________ Dose ______________ When to take (include symptoms, how often, & any other needed instruction): ____

List equipment needed to administer medication such as nebulizer or inhaler ______________________________
Additional comments: ____
____

Physician Name: ____

Address: ____

Phone number: ____

I, ____, the parent of above listed child will be at PACT activities with my child and will take the responsibility of taking care of any rescue or quick relief medication my child needs. I understand that I must keep any medication secure and out of children's reach while we are at PACT activities to prevent unintentional loss.

Parent Signature ____ date _________________

LOG for MEDICAL ALERTS/MEDICATION

Child's Name: ____ Class/Area # ___________

Log below when child has medical alert symptoms and what was done.

date	time	Describe what happened and what was done and any medication given by parent If medication given note unusual symptoms, reactions, or changes in behavior that could be due to the medication

_______ Complete for the year ____ ____________

Teacher Signature Date

When completed for year, teacher signs off and files in child's file