Grace Education Academy

STUDENT MEDICAL CONDITION NOTIFICATION

FOOD ALLERGIES

Dear Parent,

The school records indicate that your child _____ has been diagnosed with the following medical condition(s): _____

_____

In order to prepare the staff for a possible emergency concerning your child, the school staff must be made aware of your child's medical condition. Therefore, the school is asking for your permission to confidentially notify the teachers and/or staff members and/or transportation of your child's condition, in order to protect your rights, your child's safety and comply with Florida Statute 1002.22 and 381.0056. The school understands this can be a sensitive situation and assures you that information will be kept as confidential as possible.

Sincerely,

_____
Principal
_____School

PLEASE SIGN AND RETURN TO YOUR CHILD'S SCHOOL

I hereby give permission for confidential written notification to your staff of my child's medical condition.

Parent Signature: _____ Date: _____

Grace Education Academy

ALLERGY CARE PLAN

School Year _____ - _____

Student Name_____ Date of Birth_____

School Name_____ Grade_____ Teacher_____

Contact Information:

Parent/Guardian #1_____ Phone#: Home_____ Work_____ Cell_____

Parent/Guardian #2_____ Phone#: Home_____ Work_____ Cell_____

Emergency Contact_____ Relationship_____ Phone#_____

Emergency Contact_____ Relationship_____Phone#_____

Allergy Specialist_____ Phone#_____

Primary Physician_____ Phone#_____

Hospital Choice: Please circle.

Brooksville Regional Hospital Oak Hill Hospital Spring Hill Regional Hospital

Emergency Notification:

Circle the symptoms usually seen for this child (if parent/guardian(s) can't be located, 911 will be called for a student in acute distress). Shortness of Breath/Difficulty Breathing Chest tightness

Chest Pain Wheeze

Dusky Color Lips/Nails Blue in Color

Rash/Hives Straining Neck Muscles

Itching Nasal Flaring (Widening)

Vomiting Diarrhea

Unable to Speak in Complete Sentences Hunched Shoulders

Other_____

Date of Last Allergic Reaction_____

Date of Last Hospitalization_____

Student Name_____

ALLERGY MEDICATIONS AT SCHOOL/HOME

Name_____ Dosage_____ Frequency_____

Name_____ Dosage_____ Frequency_____

Name_____ Dosage_____ Frequency_____

Rescue Treatment:

Name_____ Dosage_____ Frequency_____

DOES STUDENT HAVE CONTRACT TO CARRY EPI PEN? _____YES_____NO

Allergic To: Circle all that apply.

Food (list all/be specific)_____

Insects (be specific)_____

Medications_____

Latex Cats Dogs Mold Sprays Smoke

Environmental

Allergies_____

Household

Products_____

Seasonal

Allergies_____

Other_____

List other emergency procedures for student experiencing allergic signs/symptoms _____

_____

Parent/Guardian Signature and Date_____

Public Health Nurse Signature and Review Date_____

Grace Education Academy
HEALTH CARE ACTION PLAN

Student Name _____ Date _____ _

(Copy to be readily available in classroom and office)

EMERGENCY PLAN

IN AN EMERGENCY:

1 . Stay with child

2. Call/ask someone to call Ms. Kim or Dr. Rivera-Tubbs who will assess the child and summon EMS for this child/or teacher may call EMS.

If you See this **Do This**

Based on this child's current condition a **medical emergency** for this child is:

Mother's Name: _____ Work (_} _____ Home (_) _____ _ Cell (_} _____ _

Father's Name: _____ Work(_} _____ Home (_} _____ _ Cell (_) _____ _

Emergency Contact Name: _____ Phone Number: _____ _

Preferred Hospital: _____ _

Primary Physician: _____ _

Specialist(s): ----------