Part II

HEALTH HISTORY AND EMERGENCY CARE PLAN

Directions: Please complete this form entirely. **A review by parents/guardians and staff should occur at least every annually or when needed. This form must remain with the student during the hours the student is present at Middle School U if the student has any special health care needs.**

CHILD INFORMATION:

Name (Last) (First) (Middle Name) Birthdate (M/D/Y)

Home Address (Street, City, State, Zip Code) Date - First Day of Attendance (M/D/Y)

Please fill in the student's vaccination dates below:

VACCINATIONS (DATES)	1ST	2ND	3RD	4TH	5TH
DTP Diphtheria, Tetanus, Pertussis					
Poliomyelitis (oral Sabin)					
Hib					
Hepatitis B					
MMR Measles, Mumps, Rubella					
Varicella (Chicken Pox) Or approximate date of disease					

PARENT / GUARDIAN INFORMATION: Provide information where the parent(s) / guardians(s) can be reached while the student is in care.

Name of Parent / Guardian 1 Home Phone Number Work Phone Number Cell Phone Number

Name of Parent / Guardian 2 Home Phone Number Work Phone Number Cell Phone Number

EMERGENCY CONTACT INFORMATION: A minimum of two emergency contacts other than parents is required. **Emergency contacts must be at least 18 years old and be available at the listed number during program hours.**

Name of Emergency Contact 1 Day Phone Number Complete Address Relationship to Child Auth. Pickup ☐

Name of Emergency Contact 2 Day Phone Number Complete Address Relationship to Child Auth. Pickup ☐

PHYSICIAN / MEDICAL FACILITY INFORMATION:

Name of Physician Name and Address of Medical Facility Phone Number

Please complete rest of Health History and Emergency Care Plan on the back of this form.

SPECIAL HEALTH INFORMATION (Be specific) ***Continue on separate sheet if needed.***

1. Check any special medical condition that the student may have:

   ☐ No specific medical condition ☐ Asthma ☐ Diabetes ☐ Epilepsy / Seizure Disorder

   ☐ Gastrointestinal or Feeding concerns including special diet and supplements ☐ Cerebral Palsy / Motor Disorder

☐ Emotional / Behavior Disorder including ADD or ADHD or other Mental Health concerns or diagnosis – Specify:

☐ Other condition(s) requiring special care – Specify:

☐ Food Allergies – Specify food(s):

☐ Non-food Allergies – Specify:

2. Triggers that may cause problems – Specify:

3. Signs or symptoms to watch for – Specify:

4. Steps the Middle School U staff should follow. If medications are necessary, a copy of the authorization to Administer Medication must be completed and submitted to the MSU staff. Forms are available at the office or site.
   a.
   b.
   c.

5. Medications the student takes regularly outside of program:

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

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

8. Additional information that may be helpful to the Middle School U staff:

In the event the student becomes ill or injured, I understand every effort will be made to reach me or an emergency contact person on file. I give my consent for Middle School U to act on my behalf to obtain emergency care and treatment if it is deemed necessary.

_____ _____

Signature – Parent or Guardian Date Signed

SITE USE - REVIEW DATES

_____ _____ _____ _____