SOUTH ALBANY HIGH SCHOOL
HEALTH INFORMATION

Student Name_____ Grad Year:_____

In an effort to effectively track any health concerns regarding our students, we are asking you to provide CURRENT medical information for your child. Please indicate if your child is affected by any of the following:

▶DIABETES	___ Yes	___ No	If yes, please submit a protocol from the doctor
▶SEIZURES	___ Yes	___ No	If yes, please submit a protocol from the doctor
▶ASTHMA	___ Yes	___ No	INHALER ___Yes* ___No
▶BEE STING ALLERGY	___ Yes	___ No	EPIPEN ___ Yes* ___ No ANTIHISTAMINE ___ Yes* ___ No
▶ALLERGIES	___ Yes	___ No	

If yes, please explain:_____

_____

▶OTHER:_____

_____

Emergency Action:
If your child has known SEVERE allergic reactions or other medical issues that require special immediate medical attention, please provide the details of the necessary action:

_____

_____

_____

_____

Will your child need to take medication while at school? ____ Yes* ____ No

***If yes, please fill out the Authorization for Administration by School Personnel form. We cannot administer ANY medication to a student unless it is specifically prescribed to that student by a physician. All medications MUST be in the original prescription bottle with the prescription number.**
Students ARE NOT allowed to carry any medication without proper authorization by parent and school administration.

Emergency medical permission:
In case of an emergency and immediate attention needs to be given to my child, I give my permission to, and assume full responsibility for, school authorities to send my child to a doctor or hospital. I understand the school assumes no financial obligation for expenses incurred in carrying out emergency procedures and/or emergency transportation, and every attempt will be made to reach me (parent/guardian) first.

Parent/Guardian Signature_____ Date_____

ALLERGY/ASTHMA ACTION CARD
GAPS 8J

Staff Use Only – Send Copy of Allergy/Asthma Action Card To:
☐ School Nurse ☐ Bus Garage (if riding bus) ☐ School Office

Name: _____

(DOB):_____ School Name:_____ Grade: _____ School Year: _____

Parent/Guardian Name: _____

Address: _____

Phone: (H) _____ (W)_____

Parent/Guardian Name: _____

Address: _____

Phone: (H) _____ (W)_____

Other Contact Information: _____

Emergency Phone Contact #1 _____
Name

_____ _____
Relationship Phone

Emergency Phone Contact #2 _____
Name

_____ _____
Relationship Phone

Physician Child Sees for Asthma/Allergies _____

Phone: _____

ALLERGY/ASTHMA MANAGEMENT PLAN

•Identify the things that start an asthma/allergy episode

(Check each that applies to the child)

__Animals __Bee/Insect Sting __Chalk Dust __Change In Temperature
__Dust Mites __Exercise __Latex __Molds
__Pollens __Respiratory Infection __Smoke __Strong Odors
__Food: _____
__Other: _____

Does your child use an epipen? ____ YES ____ N O

Does your child carry epipen at all times? ____ YES ____ NO

Does your child use an inhaler? ____ YES ____ N O

Does your child carry inhaler at all times? ____ YES ____ NO

Have you signed a "Self Medication Authorization Form"? ____YES ____NO

Does your child ride the bus? ____ YES ____ No Rt# _____ (Transportation Use)

MEDICATION PLAN FOR ALLERGY/ASTHMA

Name of Medication	Amount	When to Use
1.		
2		
3.		

OUTSIDE ACTIVITY AND FIELD TRIPS

*The following medications **must** accompany child when participating in outside activity, field trips, and **on the bus:***

Name of Medication	Amount	When to Use
1.		
2.		
3.		

Parental/Guardian Signature: _____ Date: _____

Rev. 11/13/13