# EARLY CHILDHOOD DEVELOPMENT CENTER
Saint Mary’s College and the University of Notre Dame

## EMERGENCY HEALTH INFORMATION AND MEDICAL PLAN
All Families Need to Complete Annually

### PART 1 - Parent or Guardian to Complete.

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Gender</th>
<th>DOB</th>
</tr>
</thead>
</table>

My child has a medical condition that may affect his or her school day  □ NO  □ YES  *(if YES, please complete Part 2, 3, 4)*

________________________________________________________

Parent/Guardian’s Name (please print)

________________________________________________________

Parent/Guardian’s Signature ______________________________________  Date

### PART 2 – Complete all boxes that apply to your child.

#### □ ALLERGIES

<table>
<thead>
<tr>
<th>Allergy type:</th>
<th>Food</th>
<th>List food(s)</th>
<th>Medication</th>
<th>List medicine(s)</th>
<th>Bee sting</th>
<th>Other (list)</th>
</tr>
</thead>
</table>

Reactions:

- Coughing
- Hives
- Rash
- Difficulty breathing
- Local Swelling
- Wheezing
- Generalized swelling
- Nausea
- Other

**Currently prescribed treatments to be used IN SCHOOL**

- Oral antihistamine (Benadryl, etc.)
- EpiPen
- Other

#### □ ASTHMA

<table>
<thead>
<tr>
<th>Triggers:</th>
<th>Exercise</th>
<th>Environmental</th>
<th>Other (list)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Restrictions:</td>
<td>None</td>
<td>Self-limits</td>
<td>Other</td>
</tr>
</tbody>
</table>

Symptoms or reactions:

- Chest tightness/discomfort/pain
- Difficulty breathing
- Throat itch/tightness/soreness
- Coughing
- Hoarseness
- Wheezing
- Other

**Currently prescribed treatments to be used IN SCHOOL**

- Inhalers
- Oral antihistamines
- Oral steroids
- Oral bronchodilator
- Nebulizer
- Peak flow monitoring

Date of last hospitalization related to asthma __________________________

#### □ DIABETES

**Currently prescribed treatments to be used IN SCHOOL**

- Insulin
- Syringe
- Pen
- Pump
- Blood sugar testing
- Glucagon
- Oral medication(s) List medication(s) __________________________________________

#### □ SEIZURE DISORDER

Type of seizure:

- Absence (staring/unresponsive)
- Complex partial
- Generalized tonic-clonic (grand mal/convulsive)
- Other (explain) __________________________________________________________
### SEIZURE DISORDER continued:

**Physical restrictions:**  
- [ ] NO  
- [ ] YES

**Medications needed in school:**  
- [ ] NO  
- [ ] YES

List medication(s) ______________________________________

Date of last seizure _______________________________  
Length of seizure _______________________________

**OTHER HEALTH CONDITIONS**

- [ ] Physical condition (be specific) _____________________________________________
- [ ] Other (be specific) _______________________________________________________

**Physical restrictions:**  
- [ ] NO  
- [ ] YES

**Medications needed in school:**  
- [ ] NO  
- [ ] YES

List medication(s) ______________________________________

**Special procedures required in school:**  
- [ ] NO  
- [ ] YES

(explain) __________________________________________________________

**VISION CONDITIONS**

- [ ] Contacts  
- [ ] Glasses

- [ ] Other ____________________________________________

**HEARING CONDITIONS**

- [ ] Hearing aid(s)  
- [ ] Other ____________________________________________

**PART 3 – PHYSICIAN’S SIGNATURE REQUIRED** if parent or guardian indicates medical condition(s) requiring medications, restrictions, monitoring and/or food substitutions.

**Symptoms to watch for:**

When to use prescribed medication(s) (please list medication/dose/route):

When to call emergency health professional:

- [ ] This child has food allergies. Please allow parent/guardian to provide store bought substitutes as needed.

**Other notes:**

Physician’s signature ____________________________________________  Date ______________________

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*Completed form may be faxed to ECDC-ND at 574-631-7808 or ECDC-SMC at 574-284-5344*

**PART 4 – EMERGENCY CONTACTS**

1. Call 911.
2. Dr. ____________________________________ Phone Number: ______________________________
3. Parent/Guardian ___________________________ Phone Number: __________________________
4. Parent/Guardian ___________________________ Phone Number: __________________________
5. Emergency Contacts:  
   Name/Relationship Phone Number(s)
   a. ____________________________________________
   b. ____________________________________________

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian’s Signature ____________________________________________  Date ______________________