Health Information

Student Name: _____ D.O.B.: _____Grade: _____

Dear Parent/Guardian:
Please complete the Health Information for your child. Include any life threatening health problems or serious medical conditions that could pose a risk for your child during the McIntosh After School Program. Return this form to Mary Mulvaney-Kemp. You may be asked to complete additional forms and emergency action plans if needed

_____ **My child does NOT have** any known health conditions or concerns

My child has the following health conditions/concerns:

____ **LIFE THREATENING Allergies:** _____
Type of reaction _____
Treatment: _____

____ **Bee Sting Allergy:** Type of reaction _____
Does student have Epi-Pen prescription? YES/NO (circle)
Epi-Pen given to school YES/NO (circle)
Epi-Pen carried in backpack YES/NO (circle)

____**Food Allergy/Intolerance:** _____Type of reaction:_____
Does student have Epi-Pen prescription? YES/NO (circle)
Epi-Pen given to school YES/NO (circle)
Epi-Pen carried in backpack YES/NO (circle)

____ **Other Allergies:** _____
Type of reaction _____

____**Asthma:** Triggers _____
Inhaler given to school YES NO (circle)
Inhaler in backpack/carried by student YES NO (circle)

____**Diabetes:** Type: _____ On Insulin: YES/NO (circle) Insulin Type: Syringe/Pump/Pen (circle)
Meter/emergency supplies given to school YES NO (circle)
Meter/emergency supplies carried by student YES NO (circle)

____**Seizures:** Type: _____ Date of last seizure: _____
Description of seizure activity_____
Length of seizures: _____On medication YES/NO (circle)

____ **ADD/ADHD** (circle) _____ On Medication YES/NO (circle)

____ **Anxiety/Depression** (circle) _____ On Medication YES/NO (circle)

____**Other Health Conditions or Concerns**: _____
_____
_____

Name of Guardian Completing form: _____
Signature: _____ Date:_____

Office Use Only
Action Plan Needed? Y/N
Action Plan Received? Y/N