

# Medical Health Alert

Program Year: \_\_\_\_\_

Classroom: \_\_\_\_\_

Child Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Yes No

Does your child have any medical conditions that require an Emergency Health Care Plan?

Does your child have any physical limitations needing special instructions?

Notes: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

## **If no medical health condition exists – DO NOT complete beyond this point.**

**This child has a medical health condition that requires an Emergency Health Care Plan.**  
(Do not list general illnesses, list only conditions that require guidance from a Doctor.)

**\*\*Follow parent’s plan until Physician’s Medical Health Alert Follow-Up/Individualized Health Plan is received\*\***

Medical Health Condition(s):	Medications (physician Rx): _____ Side effects: _____ Staff response to side effects: _____ _____ _____
Physician who child sees for this medical health condition: _____	

<i>I authorize Little Raiders staff to administer medications noted above to this child and pass these medications to all individuals listed as Emergency Contact and Release-To’s.</i>	Parent Initials: _____
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### **Parent’s Plan for Primary Medical Health Condition in the Classroom**

If you see this (symptoms to watch for):	Do this: <input type="checkbox"/> Call Parent <input type="checkbox"/> Call Physician <input type="checkbox"/> Call 911 <input type="checkbox"/> Other: _____
Additional pertinent information:   	

*I authorize Little Raiders staff to follow the above plan I have established regarding my child’s medical/health condition **until** the Physician Follow -Up, an Individualized Health Plan, or my child’s physical exam is received on file.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_