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Student Medical Information
2011-2012 School Year

Student Name: ______________________________ Date of Birth: _______ Grade: _____ Homeroom: ______

In order to ensure the safety of your child during the school day, extracurricular activities, on any field trip, and when being transported by the Chicago Public Schools (CPS) we are asking you to please complete this form. For confidentiality purposes, this information will only be shared with relevant CPS staff.

Thank you for your cooperation in this important matter.

Please indicate with a check below if applicable:

- ☐ Food Allergies: (Type) ______________________________
- ☐ Non-Food Allergies: (Type) ______________________________
- ☐ Asthma
- ☐ Diabetes: Type 1 ☐ Type 2 ☐
- ☐ Seizures
- ☐ Other Medical Condition

  ____

  ____

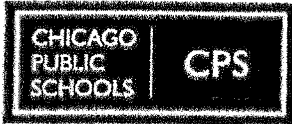
- ☐ My child has no allergies, medical conditions and/or does not take any medications during school hours.

For any medical condition identified above which requires a prescribed medication to be taken by your child during school hours, please attach to this form your child's personal physician's signed ***Emergency Action Plan***, which includes what medication is to be given during school hours, including medication frequency, and any emergency procedures to be taken. Please find attached a blank ***Emergency Action Plan*** form should your child's personal physician need to complete a new one.

Parent Name: ______________________________ Date: _________

Parent Signature: ___________________________

Revised 2/4/2011



Emergency Action Plan

Student's Name: ______________________________ **Date of Birth:** ______________
Student's ID#: ____________________ **Grade:** ________ **Room/Teacher:** ______________

Allergic to: ______________________________

Asthmatic: Yes*☐ No ☐ * Higher risk for severe reaction

♦ STEP 1: TREATMENT ♦

Symptoms:		**Give Checked Medication:** (To be determined by physician authorizing treatment)	
NONE:	If a food allergen has been ingested, but *no symptoms*	☐Epinephrine	☐Antihistamine
LUNG†:	shortness of breath, wheezing, or hacking cough	☐Epinephrine	☐Antihistamine
HEART†:	pale, blue, faint, weak pulse, dizzy, confused	☐Epinephrine	☐Antihistamine
THROAT†:	tightening of throat, hoarseness, or trouble swallowing	☐Epinephrine	☐Antihistamine
MOUTH:	itching, tickling, or swelling of lips, tongue and mouth	☐Epinephrine	☐Antihistamine
SKIN:	hives, itchy rash, swelling of the face or extremities	☐Epinephrine	☐Antihistamine
ABDOMEN:	nausea/ vomiting, abdominal cramps, or diarrhea	☐Epinephrine	☐Antihistamine
OTHER†:	______________________	☐Epinephrine	☐Antihistamine
If reaction is progressing (several of the above areas affected), give:		☐Epinephrine	☐Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

Dosage:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen®Jr. Twinject™0.3mg Twinject™0.15mg

Antihistamine: give (medication/dose/route)______________________________

Other: give (medication/dose/route)______________________________

♦ STEP 2: EMERGENCY CALLS ♦

1. Call 911: State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Dr. ____________________ at ____________________
3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. ______________________	1.__________	2. __________
b. ______________________	1.__________	2. __________
c. ______________________	1.__________	2. __________

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

Parent/Guardian Signature ______________________________ Date__________
Doctor's Name (Printed)______________________________ Phone # __________
Doctor's Signature ______________________________ Date__________
(Required)