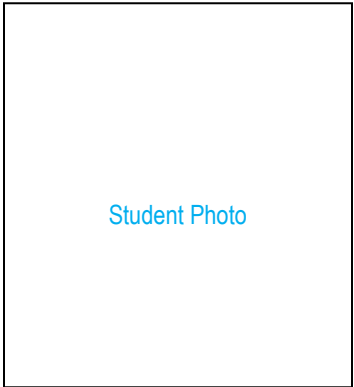




Date: _____
(DD/MMM/YYYY)

Name: _____
(student last name, first name, initial)

Grade: _____



Description of Significant Health Concern

Identify the health condition / concerns affecting the student

Life Threatening Allergies

Does the student have an epinephrine auto-injector, e.g. EpiPen? Yes No
If yes, specify location:

General Precautions / Avoidance

Identify triggers; things to avoid that may bring about a reaction or response

Signs and Symptoms

Describe signs and symptoms of reactions

Emergency Responses

Specify what to do in case of emergency including what medication to administer, who to call and what to do while waiting

Print Name Parent/Legal Guardian/Independent Student

Signature

Date (DD/MMM/YYYY)

Print Name Principal / Designate

Signature

Date (DD/MMM/YYYY)