2022-2023 EMERGENCY CARE PLAN

Parent Name _____

Student Name _____

STUDENT EMERGENCY CARE INFORMATION

Student Date of Birth_____Height_____Weight_____

Diagnoses_____

_____

ALLERGIES

1. Please list any food intolerances_____
2. If applicable, describe your child's food intolerance symptoms? _____

   _____

   _____
3. Please list any allergies _____
4. If applicable, describe your child's allergy exposure symptoms? _____

   _____

   _____
5. Does your child use an allergy treatment or medication? (Choose one) ☐ **YES** ☐ **NO**
6. If yes, please describe _____

   _____
7. Will your child be keeping a supply of this emergency allergy treatment at the school*? (Choose one) ☐ **YES** ☐ **NO**

   ***IF YES, PLEASE COMPLETE A MEDICATION PROFILE AND PERMISSION FORM**
8. Please list the criteria in which staff should administer the emergency treatment? (e.g. If the seizure lasts more than 5 minutes, If the child is having difficulty breathing, If the child begins wheezing) _____

   _____

   _____

   _____

ASTHMA

1. Does your child have asthma or issues with breathing?(Choose one) ☐ **YES** ☐ **NO**
2. If applicable, what are your child's asthma symptoms? _____

   _____

   _____
3. Does your child use an asthma treatment or medication? (Choose one) ☐ **YES** ☐ **NO**
4. If yes, please describe _____

   _____
5. Will your child be keeping a supply of this emergency asthma treatment at the school*? (Choose one) ☐ **YES** ☐ **NO**

   ***IF YES, PLEASE COMPLETE A MEDICATION PERMISSION FORM.**
6. Please list the criteria in which staff should administer the emergency treatment? (e.g. If the seizure lasts more than 5 minutes, If the child is having difficulty breathing, If the child begins wheezing) _____

   _____

   _____

   _____

SEIZURES

1. Does your child have a history of seizures?(Choose one) ☐ **YES** ☐ **NO**
2. Please indicate the estimated date of your child's last seizure_____
3. How often does your child experience seizures?_____ _____
4. How long do your child's seizures typically last?_____
5. If applicable, what are some of the symptoms and behaviors your child exhibits *prior* to having a seizure? _____
   _____
   _____
6. Does your child use seizure treatment or medication? (Choose one) ☐ **YES** ☐ **NO**
7. If yes, please describe _____
   _____
8. Will your child be keeping a supply of this emergency seizure treatment at the school*? (Choose one) ☐ **YES** ☐ **NO**

***IF YES, PLEASE COMPLETE A MEDICATION PERMISSION FORM.**

9. Please list the criteria in which staff should administer the emergency treatment? (e.g. If the seizure lasts more than 5 minutes, If the child is having difficulty breathing, If the child begins wheezing) _____
   _____
   _____

OTHER EMERGENCY DISORDERS

1. Please list any other emergency disorders you'd like Mainspring Academy to be aware of _____
   _____
2. If applicable, describe your child's symptoms? _____
   _____
   _____
3. Does your child use an emergency treatment or medication for this disorder? (Choose one) ☐ **YES** ☐ **NO**
4. If yes, please describe _____
   _____
5. Will your child be keeping a supply of this emergency treatment at the school*?(Choose one) ☐ **YES** ☐ **NO**

***IF YES, PLEASE COMPLETE A MEDICATION PROFILE AND PERMISSION FORM.**

6. Please list the criteria in which staff should administer the emergency treatment? (e.g. If the seizure lasts more than 5 minutes, If the child is having difficulty breathing, If the child begins wheezing) _____
   _____
   _____

I UNDERSTAND MAINSPRING ACADEMY WILL NOTIFY ME IMMEDIATELY IN THE EVENT OF EMERGENCIES, OR IN THE EVENT THAT STAFF MUST USE MY CHILD'S EMERGENCY TREATMENT. THE SCHOOL WILL NOTIFY LOCAL EMERGENCY SERVICES IF PARENTS ARE NOT RESPONDING TO THE SCHOOL'S COMMUNICATIONS, SYMPTOMS ARE SEVERE, TREATMENTS ARE INEFFECTIVE, OR IF SYMPTOMS PERSIST.

MY PREFERRED HOSPITAL IN CASE OF AN EMERGENCY IS _____. HOWEVER, IN THE EVENT A HOSPITAL OR FACILITY IS NOT INDICATED AND I CANNOT BE REACHED, I GIVE PERMISSION TO THE PHYSICIAN OR HOSPITAL SELECTED BY THE SCHOOL TO SECURE PROPER TREATMENT AND MEDICAL CARE (E.G. MEDICATION, ANESTHESIA, SURGERY, ETC.) FOR MY CHILD.

I AM RESPONSIBLE FOR REPLENISHING MY CHILD'S SUPPLY OF THEIR EMERGENCY TREATMENT AT THE SCHOOL. DEPENDING ON THE SEVERITY OF THE DISORDER/EMERGENCY, MY CHILD MAY NOT RETURN TO SCHOOL UNTIL I PROVIDE A NEW SUPPLY. IF I DO NOT HAVE AN EMERGENCY PROTOCOL, MAINSPRING ACADEMY RESERVES THE RIGHT TO POSTPONE MY CHILD'S RETURN UNTIL MY CHILD HAS SEEN A PHYSICIAN OR UNTIL I CAN PROVIDE A NEW EMERGENCY TREATMENT TO BE KEPT AT THE SCHOOL. I AM RESPONSIBLE FOR PROMPTLY COMMUNICATING WITH MAINSPRING ACADEMY'S MEDICATION ADMINISTRATION TEAM ABOUT ANY CHANGES REGARDING MY CHILD'S SYMPTOMS, CRITERIA, AND TREATMENT.

I UNDERSTAND THAT, I MUST PICK UP MY CHILD AFTER AN EMERGENCY HEALTH INCIDENT TO ALLOW FOR MY FURTHER MONITORING AND A PROPER REST PERIOD FOR THE REMAINDER OF THE DAY.

Parent Signature_____Date_____

2022-2023 MEDICAL HISTORY FORM

Parent Name _____

Student Name _____

STUDENT EMERGENCY CARE INFORMATION

PLEASE CHECK YES OR NO FOR THE FOLLOWING HEALTH INFORMATION CONCERNING YOUR CHILD. BE SURE TO INCLUDE ANY RECENT (PAST 6-12 MONTHS) INJURIES, ILLNESSES, OR SURGERY THAT IS IN THE STUDENT'S HEALTH HISTORY WHICH COULD INFLUENCE PARTICIPATION IN ACTIVITIES OR OTHER NEEDS.

		DESCRIPTION
Arthritis/joint or bone condition	□ Yes □ No	_____
Asthma/Reactive Airway Disease	□ Yes □ No	_____
Bleeding/blood disorder (e.g. anemia, hemophilia, sickle cell disease, etc)	□ Yes □ No	_____
Developmental condition/consideration	□ Yes □ No	_____
Diabetes	□ Yes □ No	_____
Digestive/stomach condition	□ Yes □ No	_____
Dental/orthodontic appliance or other prosthesis	□ Yes □ No	_____
Eyeglasses/contacts/vision	□ Yes □ No	_____
Fainting/lightheaded episodes/heat sensitivity	□ Yes □ No	_____
Hearing loss	□ Yes □ No	_____
Heart condition or chest pain with exercise	□ Yes □ No	_____
High blood pressure	□ Yes □ No	_____
Seizure disorder	□ Yes □ No	_____
Immune system disorder (e.g. mono, chronic fatigue syndrome, chemotherapy, etc.)	□ Yes □ No	_____
Menstrual disorder/difficulties	□ Yes □ No	_____

Significant fears/phobias	□ Yes □ No	_____
Sleepwalking or sleep time difficulties	□ Yes □ No	_____
Toileting consideration	□ Yes □ No	_____
Orthopedic condition, recent injury, back pain	□ Yes □ No	_____
Other (please specify)	□ Yes □ No	_____

Please specify any dietary restriction/needs:

□ Vegetarian □ No milk/dairy □ Soy □ Casein □ Whey □Other

_____

Please specify any injuries/surgeries/major illness in the past 6 to 12 months:

Type Date

_____ _____

_____ _____

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. IN CASE OF EMERGENCY AND I CANNOT BE REACHED, I GIVE PERMISSION TO THE PHYSICIAN OR HOSPITAL SELECTED BY THE SCHOOL REPRESENTED TO SECURE PROPER TREATMENT AND MEDICAL CARE (E.G. MEDICATION, ANESTHESIA, SURGERY, ETC.) IN CASE OF EMERGENCY OR AS SPECIFIED ABOVE FOR MY CHILD.

Parent Signature_____Date_____