

EMERGENCY MEDICAL INFORMATION FORM

PARENT/GUARDIAN: Please fill out this form if your child has asthma, diabetes, seizures, requires the use of an EpiPen, or other severe medical conditions of allergies. It will provide important information in the event of an emergency to coaches, chaperones, or other adult supervisors during after-school, sports, or other extracurricular activities. Please note that the school nurse is not present during after-school and extracurricular activities including sports and field trips.

1 STUDENT INFORMATION

STUDENT NAME		CURRENT GRADE	
STUDENT ADDRESS	CITY	STATE	ZIP
PARENT GUARDIAN 1	PHONE	CELL PHONE	WORK PHONE
PARENT GUARDIAN 2	PHONE	CELL PHONE	WORK PHONE

2 ACTION PLANS

My child has the following medical condition(s) that may require immediate attention (911) at an after-school, extracurricular, or athletics activity.

☐ **ALLERGIC REACTIONS** (requiring the use of EpiPen or EpiPen Jr.)

SYMPTOMS: Examples of some of the symptoms include difficulty breathing, shortness of breath, wheezing, difficulty swallowing, hives, itching, swelling of any body part. | **ACTION PLAN:** Call 911 and assist child in using EpiPen if prescribed. See attached form.

☐ **ASTHMA**

SYMPTOMS: Student has difficulty breathing, wheezing, or shortness of breath. | **ACTION PLAN:** If student has inhaler, allow them to use it. If no relief of symptoms in five minutes, call 911. If no inhaler is available, call 911 immediately. See attached form.

☐ **DIABETES**

SYMPTOMS: *Low Blood Sugar Reaction:* hunger, sweaty, pallor, feels shaky, headache. *High Blood Sugar Reaction:* very thirsty, fatigued, fruity breath odor, stomach pain, headache. | **ACTION PLAN:** Please see attached form. If symptoms worsen, call 911.

☐ **SEIZURES**

SYMPTOMS: Student has altered consciousness, involuntary muscle stiffness or jerking movements, drooling or foaming at the mouth, temporary halt in breathing, or loss of bladder control. | **ACTION PLAN:** Call 911 and please see attached form.

☐ **OTHER**

PLEASE LIST ANY OTHER MEDICAL CONDITIONS ABOVE

PARENT/GUARDIAN SPECIFIC INSTRUCTIONS

PARENT/GUARDIAN SIGNATURE

DATE



CATHEDRAL
7-12 HIGH SCHOOL • BOSTON

PLEASE RETURN THIS COMPLETED FORM TO:

MAIL: Cathedral 7-12 High School, Health Office, 74 Union Park St., Boston MA 02118

FAX: (617) 542-1745