Montessori Community School Est. 1985 Salt Lake City, Utah

Medical Action Plan

Allergies & Medical Conditions

Name of your Child: _____ Date: _____

Father's Name: _____ Phone Number: _____

Mother's Name: _____ Phone Number: _____

Pediatrician's Name: _____ Phone Number: _____

Your local hospital:_____ Phone Number: _____

Please select your child's medical condition:

□ Allergies
□ Asthma
□ Other (please be specific): _____

_____

If you selected Box 1, please go on to complete Form A. If you selected Box 2, please go on to complete Form B. If your child has an alternate medical condition that fits under Box 3, or "other" please see Form C.

Form A) Allergies

1. List of Allergies. Please indicate the severity of each allergy:

_____

_____

_____

2. Does your child have an Epi-pen? Yes or No

3. Please give us instructions on how you would like the Epi-pen administered:

☐ If checked, give epinephrine ONLY if my child does not respond to Benadryl.

☐ If checked, give epinephrine immediately for ANY symptoms if my child was *exposed* to the allergen.

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

4. What is the Medical Action Plan recommended by your child's Pediatrician?

_____

_____

_____

_____

5. Please give us any other details that we should be aware of, in order to care for your child's allergic reaction on-site:

_____

_____

_____

_____

Please be informed that our school policy on Epi-pens requires that they be kept in the classroom, out of reach of the children, inside class field trip backpacks.

Form B) Asthma

1. Please select the Asthma Type that your child experiences:
□ Allergy-Induced Asthma
□ Exercise-Induced Asthma
□ Cough-Variant Asthma
□ Night-time Asthma

2. Please indicate the frequency that your child uses his/her inhaler:
□ Daily
□ Emergency
□ Both

3. Explain your child's Asthma triggers:

_____

_____

4. List the controller medications prescribed to your child, and the usual dosage.

_____

_____

5. Does your child suffer from Asthma attacks? Yes or No

6. What symptoms are usually present when your child is experiencing an Asthma attack?

_____

_____

7. What is the Medical Action Plan recommended by your child's Pediatrician?

_____

_____

_____

_____

8. Please give us any other details that we should be aware of regarding your child's medical condition:

_____

_____

_____

_____

Form C) Alternate Medical Condition

1. Please inform us of your child's medical condition:

_____

_____

2. List the medication prescribed to your child, and the usual dosage.

_____

_____

3. What is the Medical Action Plan recommended by your child's Pediatrician?

_____

_____

_____

_____

4. Please give us any other details that we should be aware of regarding your child's medical condition:

_____

_____

_____

_____

*If there is any additional information you would like to include, please write this on the space provided below.

Montessori Community School Est. 1985
Salt Lake City, Utah

Medication Release Form

(To be completed by Parent or Guardian)

Name of Student: _____ Age of Student: _____

Name of Medication: _____

Date(s) to be given: _____ Time(s) to be given: _____

Dosage: _____

Illness/Condition being treated: _____

Additional Instructions or Comments: _____

_____

I hereby give authorization for the staff of the Montessori Community School to administer the above medication according to the above instructions. I recognize that the staff will not be held liable for any illness or injury resulting from the administration of this medication, and will not be held responsible for reimbursement of medical expenses resulting from such action. I understand that medication must be in the container in which it was prescribed and must be specifically for the child named.

Signature of Parent or Guardian _____ Date _____

For Staff Use Only

DATE	TIME	DOSAGE	MEDICATION	ADMINISTERED BY