HEALTH ALERT FORM

Child's Name: _____ Date: ____/____/____
Last First

Staff Name: _____ Title: _____

Form Instructions:

Staff please complete this form and have parent/guardian sign.

Check applicable Health Alert below:

____Health Check indicated area of concern ____ Medication side effects or concerns

____Reaction to food and/or drink ____Accident and/or injury

____**Signs & Symptoms of illness*** ____Other _____

Staff in the area below: provide details to parent of the Health Alert (concern, reaction, side effect, accident/injury), and what actions were taken (who, what, where and when):

_____
_____
_____
_____
_____

***Signs & Symptoms of illness; please refer to section below:**

Do the child's sings & symptoms of illness indicate that short-term exclusion be implemented?

____yes ____no. ***If yes, follow short-term exclusion policy * Procedure.**

If Short-Term Exclusion is implemented, a note from a physician is required for re-admission to campus.

Staff notified Campus Supervisor and calls parent/guardian. If a referral to a medical provider or family assistance is needed, contact Family Services.

Complete the following when the parent/guardian picks up the child for the day.

Parent/Guardian:	Staff:	Physician Note Required:
X_____ Parent/Guardian Signature Date____/____/____ Time:_____	**X**_____ Staff Signature Date____/____/____ Time:_____	_____Yes _____No

Routing instructions: Original to Health Specialist: Copy to Parent and Copy to child's file.

Accident Report

Name of Injured: _____Date of Birth: _____

Site/Campus: _____Classroom Teacher: _____

Date/Time of Accident: ___/____/____ _____: _____a.m./p.m. (circle one)

Location Accident Occurred: _____

_____

Nature of injury: (check one) □fall/bump □bitten by another child □ hit/scratched by another child
□nosebleed □burn □ other-specify: _____

Briefly describe events proceeding and following accident: (facts only)

_____

_____

_____

A. Was Emergency Pathway taken? ___ yes ____ no. If yes, why _____

_____

B. Was on site First Aid Administered? ___yes ____ no. If yes, explain who did what, when, etc.

_____

_____

_____

C. Was parent/Guardian notified? ____ yes ____ no. Did Parent/Guardian pick child up? ____ yes _____ no
When? (time) _____

D. Is follow-up treatment needed with a Medical Provider? ____ yes ____no. If yes, why and what occurred?

_____

_____

Name/*Title/Address/Phone Number of witnesses:

_____

_____

_____

_____ _____/_____/_____
Signature of (1) witness *Title Date

_____ _____/_____/_____
Signature of Reporting Staff *Title Date

*Title= Staff, By-stander, Parent, Volunteer Original form to Health Specialist Copy to child's file and to Parent