NOVATO UNIFIED SCHOOL DISTRICT

CRITICAL HEALTH CONCERNS

HEALTH ALERT TO SCHOOL NURSE

Dear Parent or Guardian,

Complete this form only if your child has a **critical** health condition or takes medication for a **serious** medical condition that the school nurse should be aware of. For example:

- Diabetes
- Seizure Disorder –Type: _____ Last seizure date: _____
- **SEVERE** asthma or exercise induced asthma **that requires a rescue inhaler** at school.
- Anaphylaxis/Life threatening allergies **requiring emergency epinephrine injection.**
- Other serious health conditions (i.e. heart/blood disorders, bowel/kidney disorders, etc.)

Student name: _____ Birthdate: _____

Grade: _____ School: _____

Critical Health Condition: _____

Medications* or treatment required: _____

_____

***Ask the office staff for the medication authorization form to take to your healthcare provider if your child needs to take medication at school or for the 72 hour medication form if your child takes medication that they would need to take after school hours in case of emergency or disaster.**

Home phone: _____ Cell phone: _____

Date completed: _____ Email address: _____

Parent/guardian name: _____

Signature: _____

PLEASE RETURN THIS FORM TO THE SCHOOL OFFICE ASAP

For nurse's use only **Date received:** **Signature:** **Notes:**_____ _____ _____ _____ _____ _____