

# 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:

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|--|--|
| <input type="checkbox"/> Health Check indicated area of concern  | <input type="checkbox"/> Medication side effects or concerns |
| <input type="checkbox"/> Reaction to food and/or drink           | <input type="checkbox"/> Accident and/or injury              |
| <input type="checkbox"/> <b>Signs &amp; Symptoms of illness*</b> | <input type="checkbox"/> 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):

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**\*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:  <hr/> <b>X</b> Parent/Guardian Signature  Date ____/____/____ Time: _____	Staff:  <hr/> <b>X</b> Staff Signature  Date ____/____/____ Time: _____	Physician Note Required:  _____ Yes  _____ No
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Routing instructions: Original to Health Specialist: Copy to Parent and Copy to child's file.