Horizons Health Plan
Health Information for chronic conditions and/or allergies
2021

Student Name: ____

Grade: _____________ Site: SAS SCDS SCPS BETHESDA (grades 6-8)

Condition in need of treatment (check all that apply):

_______ Asthma

_______ **Life threatening** allergy to : _____________________________________

_______ Mild (not life threatening) allergy that requires treatment to:

____

________ Other chronic condition that requires care- including administering any medication on a daily basis AT HORIZONS (please describe):

____

Please treat the following symptoms immediately in this way:

Symptom	Treatment (include dosage)

Call 9-1-1 if the following occurs:

____

____

Will child carry his/her own inhaler or epi-pen? YES NO

If Yes, initial here that you acknowledge that your child is capable of administering their own inhaler or epi-pen without Horizons faculty/staff assistance and that you acknowledge that you are responsible for ensuring your child has the needed medication on his/her person at all times while at Horizons: ____________

Routine medicine to be given by Horizons staff during Horizons hours:

Medication	Dose	Time

Does your child take any other medications that we should be aware of in case of emergency? If so, please list here.

Medication	Dose	Time

Does your child have any restrictions on activities that normally take place during Horizons (running, swimming, etc.)?

____

____

By signing below, you acknowledge that you have provided information to assist Horizons staff with your child's general well-being. You are giving permission for staff to treat your child according to this health plan, and/or any first aid or reasonable intervention they deem necessary for your child's safety or well-being. You are giving permission for Horizons staff to administer medication as outlined on this form during the summer program. In case of any medical emergency, every effort will be made to contact you, but you acknowledge that Horizons staff will seek medical assistance on your child's behalf should it be considered necessary as soon as possible. Should my child's health status change, I will notify Horizons immediately.

Parent or Guardian Signature:

____

Printed Name: Date:

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