A logo with a cross in a circle

Description automatically generated

St. Gregory the Great Catholic School 2024-2025

**Life Threatening Emergency Medical Form**

(EDUCATION CODE SECTION 49423)

Place

Picture

Here

* Use of this form is limited **only to students with life threatening medical conditions** that may require the emergency administration of an epinephrine auto-injector or other emergency medical attention.
* Please ensure that this form is filled out completely, legibly and in pen.
* This form shall be updated yearly and/or as medical information changes.

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Life Threatening Medical Condition(s):**

□ Allergy/Anaphylaxis to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* My child needs to sit at the allergy lunch table: □ YES □ NO
* HISTORY OF ANAPHYLAXIS? □ YES □ NO

□ Asthma

□ Diabetes

□ Seizure

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACTION PLAN**: List steps to be taken in a concise and legible format:

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read and accept conditions set forth by St. Gregory the Great Catholic School for Emergency Medical Treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name (PRINT) Parent/Guardian Signature Date

|  |  |  |
| --- | --- | --- |
| **MEDICATION** | **DOSAGE** | **INSTRUCTIONS** |
|  |  |  |
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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name (PRINT) Physician’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CA Medical License Number Phone Number Fax