University of Hawai‘i at Mānoa Children’s Center  
Chronic Illness/Allergies Health Record

Staff of UHMCC is only authorized to administer first aid and prescription medication. Any additional treatment needs to be administered by parent(s) or trained health professional(s). Include on this form the first aid/medication we need to administer and when to call parents/health professionals.

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<tr>
<th>Name of child</th>
<th>Birthdate</th>
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<table>
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<tr>
<th>Semester</th>
<th>Year</th>
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<thead>
<tr>
<th>Parent's name</th>
<th>Ph (c)</th>
<th>Ph (w)</th>
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Parent/Guardian’s Signature  

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Physician’s/NP/APRN/PN or Clinic Name, Address, Zip, Phone, Fax

Physician’s Signature  

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1. Which health problem (chronic illness) does the child have?
   - Allergies to ________________
   - Anemia
   - Asthma
   - Diabetes
   - Epilepsy
   - Heart trouble
   - Kidney trouble
   - Sickle-cell disease
   - Other ________________

2. What symptoms does the child exhibit when he/she has a crisis related to the condition?

3. What procedures would the staff follow to...
   a. Prevent these crises?
   b. Deal with them when they occur?

4. Does the staff need to be trained in any particular emergency procedures (e.g., CPR)? If so, which one(s)?

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**Items 2, 3, and 4 need to be completed with the child’s physician’s approval unless no first aid treatment or medication is required.**
5. What medication(s) does the child take?  
*If medication is to be administered by staff, attach Chronic Illness/Allergies Permission to Administer Medication form.

a. Are there any side effects (including behavioral)? From which medicines?

e. ___ Naptime routine. Explain.

f. ___ Toileting. Explain.

g. ___ Other. Explain.

6. Check all of the program areas that require any changes. Tell us what changes or special arrangements need to be made.

a. ___ Diet or feeding. What?

b. ___ Order of activities. Describe.

c. ___ Types of activities. Describe.

d. ___ Length of activities. Describe.

7. Name of person(s) other than yourself or your physician to contact for questions about your child’s condition if you are unavailable.

Person: ____________________________  
Relationship to child: ____________________________  
Phone: ____________________________

Person: ____________________________  
Relationship to child: ____________________________  
Phone: ____________________________

8. Any other information you feel we should have: