

Individualized Healthcare Plan/Emergency Action Plan	School Year:	Picture
---	--------------	---------

STUDENT INFORMATION

Student:	DOB:	School/Grade:
Parent:	Phone:	Email:
Physician:	Phone:	Fax:
School Nurse:	School Phone:	Fax:

BRIEF MEDICAL HISTORY

Baseline Status: (Healthy? Decreased Immunity?)

Allergy/Anaphylaxis to:
 Asthma
 Diabetes
 Seizures
 Other:

Parent: complete the above section, read and sign below, obtain signature from Health Care Provider, and return to school nurse. No accommodations can be made until signed IHP/EAP, medication order, or IEP/Section 504 Plan are on file with the school.

As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.

Parent Signature: _____ **Date:** _____

EMERGENCY ACTION PLAN

<i>If you see this</i>	<i>Do This</i>

EMERGENCY PROTOCOL	Expected Behavior After Event	Follow Up
<input type="checkbox"/> Call 911 <input type="checkbox"/> Transport to _____ <input type="checkbox"/> Call parent or emergency contact <input type="checkbox"/> Administer emergency medications <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tiredness <input type="checkbox"/> Weakness <input type="checkbox"/> Sleeping, difficult to arouse <input type="checkbox"/> Regular breathing <input type="checkbox"/> Other: _____	<ul style="list-style-type: none"> Document Call School Nurse Other:

SPECIAL CONSIDERATIONS

Special Health Care Needs: (Problems we need to deal with at school: Feedings? Oxygen? Respiratory problems?)

Special considerations and precautions:

Transportation-Special care required? No Yes, please specify:
 Comments:

EMERGENCY OR RESCUE MEDICATIONS
--

Person to give rescue medication: School Nurse, Parent, EMS, Volunteer(s) (Specify): _____

Medication	Dose	Route	Time	Side Effects

Location of rescue medication:

ROUTINE MEDICATIONS

Person to give routine medication at school: School Nurse School Staff (Specify): _____

Medication	Taken at Home or School?	Dose	Route	Time	Side Effects

Location of routine medication:

SIGNATURES

The above named student is under my care. The above reflects my plan of care for the above named student.

Healthcare Provider Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____