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

If you see this	***Do This***

EMERGENCY PROTOCOL	**Expected Behavior After Event**	**Follow Up**
□ Call 911 □ Transport to _____ □ Call parent or emergency contact □ Administer emergency medications □ Other_____	□ Tiredness □ Weakness □ Sleeping, difficult to arouse □ Regular breathing □ Other: _____	• 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_____