EMERGENCY ACTION PLAN

VARIOUS HEALTH ISSUES

Student's Name_______________________________DOB__________School__________________

Grade______Teacher_________________________Bus #________Daycare?_____

HEALTH CONCERN: ____
(Medical condition)

Is student on medication for this problem? ______yes ______no
Please list below:

At home? ____

At school? ____

Briefly describe symptoms: ____

____

Is exercise or activity limited? ______yes ______no **If yes, please describe limitations**:

____

OTHER HEALTH PROBLEMS:

Briefly describe: ____

____

PLEASE NOTE: If medications are to be taken at school, a "Physician's Authorization for Medication" form must be completed by parent and physician and kept at school. These are obtained from your office staff or school nurse and must be completed on a yearly basis for each medication.

PLEASE READ THE EMERGENCY ACTION PLAN ON THE REVERSE SIDE AND COMPLETE IT, SIGN IT AND RETURN IT TO THE SCHOOL NURSE.

EMERGENCY PLAN

Student's Name___________________________________Teacher______________________

Emergency contact: ___________________________________Ph:______________

Healthcare Provider: ___________________________________ Ph: ______________

SIGNS OF EMERGENCY: ____

____

____

ACTIONS AND TREATMENT FOR SCHOOL PERSONNEL TO TAKE:

1. ____
2. ____
3. ____
4. ____
5. ____

ADDITIONAL INSTRUCTIONS: ____

This medical information needs to be shared with your child's teachers, office personnel, and bus drivers, if necessary. By signing below, the school nurse has your permission to share the above Emergency Action Plan with the school personnel mentioned above.

PARENT/GUARDIAN SIGNATURE ____ DATE _______________

NURSE ____ DATE _______________