INDIVIDUAL HEALTH CARE/EMERGENCY PLAN FOR STUDENTS WITH A MEDICAL CONDITION

TO BE RENEWED EACH SCHOOL YEAR

(If you need assistance completing this form, contact the Licensed School Nurse)

Student Name: ______________________________ Birth Date: ____________________

School: ____________________ Grade: _____ Teacher: ______________ School Year: ______________

Primary Care Provider: ________________ Clinic: ________________ Phone # ______________

DIAGNOSIS:

By typing my name on the line below I understand and acknowledge that electronically signed documents will be valid and enforced in the same manner as a hand-signed document and that a record or signature will not be denied legal effect or enforceability under law solely because it is an electronic form.

This diagnosis is no longer a concern. Parent/Guardian Signature: ______________________ Date: ____________

(If no longer a concern, do not complete the remainder of the form, but sign above and return to your child's school.)

1) Could this condition be life threatening? Yes ___ No ___
2) What signs and/or symptoms of your child's condition should we be aware of?
   ____
   ____
3) Does your child recognize these signs and symptoms? Yes ___ No ___
4) List any known triggers (things that make symptoms worse). ______________________________
5) Are there any classroom and/or physical education limitations for your child? Yes ___ No ___
   If yes, please explain: ____
   ____
6) Will your child need any treatment or medications at school related to this condition? Yes ___ No ___
   If yes, please explain: ____

If medication is needed at school, please complete "Consent Form For Administration of Medication During the School Day"

7) What is an emergency for your child and what should be done? ______________________________
   ____

***Standard Emergency Plan is to call 911 and notify parent/guardian.**

Emergency Contacts

Name: ____________________ Relationship: ________ Daytime Phone: _________ Cell: __________

Name: ____________________ Relationship: ________ Daytime Phone: _________ Cell: __________

Name: ____________________ Relationship: ________ Daytime Phone: _________ Cell: __________

PARENT/GUARDIAN AUTHORIZATION

1. I give consent for this plan to be shared with all school staff working directly with my child.
2. I will contact the Licensed School Nurse if a change in the current plan is indicated.
3. I authorize the Licensed School Nurse/designee to exchange information related to my child's condition with my child's primary care provider.
4. I will contact the Licensed School Nurse if there are special accommodations needed for school field trips.
5. **I understand if my child rides the school bus and/or participates in before or after school activities, it is my responsibility to inform the staff/bus company of my child's health plan.**

Parent/Guardian Signature: ________________________________ **Date** ____________

Licensed School Nurse Signature: ____________________________ **Date** ____________