

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: _____

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 _____