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. (Do not complete the remainder of this form., but sign, date 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** __________