

School Year

20_____

ELIZABETHTON CITY SCHOOLS**STUDENT ACTION PLAN**

To be completed by

Parent/School Nurse/Doctor

Condition for which this plan is created: _____

Child Information:

Name: _____ Date of Birth: _____

School: _____ Grade: _____ Homeroom Teacher: _____

Emergency Information:

Date of Care Plan: _____

Parent/Guardian Names: _____

Mother's Phone _____ Father's Phone: _____

In the event a Parent/Guardian cannot be reached, please list other adults that may be contacted in the event of an emergency that may pick up your child and/or accompany your child to the Emergency Room if needed.

1. Name: _____ Relation: _____ Telephone: _____

2. Name: _____ Relation: _____ Telephone: _____

Student Medical Information:

Student's Primary Physician: _____ Office #: _____

Address: _____

ALLERGIES: ☐ NO ☐ YES (specify): _____**ALL CURRENT MEDICATIONS: use back of sheet if needed.**

Name of Medication	Dosage and Strength	Purpose	Time of Day Given

TREATMENT PLAN (To be filled out by HealthCare Provider): _____**RESTRICTIONS ON DAILY ACTIVITIES** (To be filled out by HealthCare Provider): _____

HEALTHCARE PROVIDER SIGNATURE: _____ DATE: _____

I give permission for the Elizabethton City School nursing staff and my child's HealthCare provider to exchange protected healthcare information in order to clarify and/or maintain an Emergency Care Plan for my child.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

I understand that it is my responsibility to keep this information current and to provide an updated form on at least an annual basis. I agree to maintain an adequate supply of medication at school. I give my permission for school personnel, who volunteer under no duress and are trained by a Registered Nurse, to participate in the care of my child in the event a school nurse is not present. I hereby agree and understand that the Elizabethton City School system and its personnel shall not be held liable for any injury resulting from the reasonable and prudent assistance in the administration of medication/treatment to my child. I give permission for the school nursing staff to share protected healthcare information with other school staff members on a need to know basis.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____