

School Year: _____

Student Emergency Action Plan

Student Name: _____ Date of Birth: _____

Grade: _____ Teacher/Advisor: _____ Allergies: _____

Emergency Information	
Parent/Guardian Name(s): _____	
Primary Phone Number: _____	Other: _____
Physician Name: _____	Number: _____
Emergency Contact: 1. _____ Phone: _____ 2. _____ Phone: _____	
Health Condition (list): ☐ Anaphylaxis ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Other (please describe): _____ _____ _____	
Physician Orders Provided to School: ☐ Yes ☐ No	
Condition Details (History/Symptoms/Triggers): _____ _____ _____ _____	
Treatment at School/Actions to be Taken: _____ _____ _____ _____	
Emergency Medications to be given (Medication Authorization Form Must be on file): 1: _____ 2: _____ 3: _____	
Additional Comments: _____ _____ _____	

School Year: _____

Please advise us as to where medications will be stored at school:

- ☐ Emergency Medication will be stored in the red backpack (PreK and Lower School Only)
- ☐ Emergency Medication will be stored in the appropriate division office
- ☐ Emergency Medication will be stored in the child's backpack
- ☐ Other medication _____ (medication name) will be stored in the appropriate division office
- ☐ Other medication _____ (medication name) will be stored in the nursing office
- ☐ Other (please describe):

This information will be distributed to appropriate school personnel on a need-to-know basis.

☐ I, the undersigned Parent/Guardian of _____, authorize a school nurse or appropriate staff member to administer medication or treatment to my student according to the physician's instructions or medical management plan. I give permission to the school nurse or another qualified health care professional to collaborate with my child's physician/health care provider as needed. I agree to provide all equipment, supplies, medication, or other items necessary to provide the appropriate care to my student. I agree to notify the school nurse immediately if there is any change in my student's status or physician's orders. The school nurse reserves the right to monitor the student periodically throughout the year.

☐ I, the undersigned Parent/Guardian understand that the school nurse is not always in the building and trains non-medical school staff to administer medication (routine and emergency) to assist with medical treatment as outlined in my student's emergency action plan. Additionally, the undersigned agrees to hold the school personnel harmless for any injuries resulting from the emergency care unless the injury was caused by the trained staff's negligence.

Parent/Guardian Signature: _____

Date: _____