Grand Rapids Area Schools

Resilience, Readiness, Excellence

INDIVIDUAL HEALTH CARE/EMERGENCY PLAN FOR STUDENTS WITH A MEDICAL CONDITION (TO BE RENEWED EACH SCHOOL YEAR).

Student Name: _____

Birth Date: _____

School: _____

Grade: _____

Teacher: _____

School Year: _____

Primary Care Provider: _____

Clinic:_____

Phone #: _____

DIAGNOSIS:_____

_____Please note: If this diagnosis is no longer a concern. (Skip to the end of this form, sign, date and return to your student's school.)

1) Could this condition be life threatening? **YES NO**

2) What signs and/or symptoms of your student's condition should we be aware of?

_____

_____

_____

3) Does your student 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 student? **YES NO** If yes, please explain:_____

7) Will your student 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 the Medication Form found on district website: Isd318.org□Departments□Health Services□form found under the Tabs section.

8) What is an emergency for your student and what should be done:_____
_____***Standard Emergency Plan is to call 911 and notify parent/guardian.**

Emergency Contacts Name: _____ Relationship: _____ Daytime Phone: _____ Cell: _____

PARENT/GUARDIAN AUTHORIZATION 1. I authorize the Licensed School Nurse/designee to communicate with appropriate school personnel regarding his/her health plan. 2. I authorize the Licensed School Nurse/designee to exchange information with my student's health care provider related to his/her health plan. 3. I will contact the Licensed School Nurse/designee if a change in the current plan is indicated. 4. I understand if my student 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 student's health plan.

Parent/Guardian Signature:
_____ Date:_____

Licensed School Nurse Signature:
_____ Date:_____