



Health Services Department

**Emergency Action Plan
Annual Parental Review**

Student Name: _____ School Year: _____

Grade: _____

I/We, the parent(s) or legal guardian of the student listed above, have reviewed:

Asthma Action Plan	Dated: _____
Severe Allergy Action Plan	Dated: _____
Seizure Action Plan	Dated: _____

I/We agree that this/these action plan(s) are still current for my student without any changes in medication(s) or treatment plan, and authorize district employees to continue to use this plan for this school year. I understand that if there are any changes that develop, I/We are responsible for informing the school nurse and obtaining a new emergency action plan from my student's physician. If I/We fail to do so, I/We hereby release the District, its agents and employees from all liability and damages as a result of any injury arising from following the initial plan by school staff, regardless of fault or negligence, and agree to indemnify and hold harmless the District, its agents and employees therefrom.

Signature of Parent or Legal Guardian: _____

Printed Name of Parent or Legal Guardian: _____

Emergency Contact and Phone Number: _____

Additional Contact and Phone Number: _____

Date: _____

Note: Other forms that are required to be completed in addition to this form:

-Medication Authorization Form

-Parental Annual Authorization for Student Self-Administration Form

Updated February, 2026