**STUDENT INFORMATION**

<table>
<thead>
<tr>
<th>Student:</th>
<th>DOB:</th>
<th>Grade:</th>
<th>School:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>Phone:</td>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Physician:</td>
<td>Phone:</td>
<td>Fax or email:</td>
<td></td>
</tr>
<tr>
<td>School Nurse:</td>
<td>School Phone:</td>
<td>Fax or email:</td>
<td></td>
</tr>
</tbody>
</table>

**BRIEF MEDICAL HISTORY**

Baseline Status: (Healthy? Decreased Immunity?)

- [ ] Allergy/Anaphylaxis to:
- [ ] Asthma
- [ ] Diabetes
- [ ] Seizures
- [ ] Other (specify):

**Parent**: complete the above section, read and sign below, obtain signature from Health Care Provider, and return to school nurse. No accommodations can be made until signed IHP/EAP, medication order, or IEP/Section 504 Plan are on file with the school.

As parent/guardian of the above named student, I give permission for my child’s healthcare provider to share information with the school nurse for the completion of this plan. I understand the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student’s health status, care or medication order. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.

**Parent Signature:**

**Date:**

**EMERGENCY CARE PLAN**

<table>
<thead>
<tr>
<th>If you see this</th>
<th>Do This</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call 911</td>
<td></td>
</tr>
<tr>
<td>Transport to:</td>
<td></td>
</tr>
<tr>
<td>Call parent or emergency contact</td>
<td></td>
</tr>
<tr>
<td>Administer emergency medications</td>
<td></td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
</tr>
</tbody>
</table>

**EMERGENCY PROTOCOL**

- [ ] Tiredness
- [ ] Weakness
- [ ] Sleeping, difficult to arouse
- [ ] Regular breathing
- [ ] Other (specify):

**Follow Up**

- Document
- Call School Nurse
- Other:

**SPECIAL CONSIDERATIONS**

Special Health Care Needs: (Problems we need to deal with at school: Feedings? Oxygen? Respiratory problems?)

Special considerations and precautions:

Transportation-Special care required?  No  Yes, please specify:

**EMERGENCY OR RESCUE MEDICATIONS**

Person to give rescue medication:  School Nurse  Parent  EMS  Volunteer(s)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Time</th>
<th>Side Effects</th>
</tr>
</thead>
</table>

Location of rescue medication:

**ROUTINE MEDICATIONS**

Person to give routine medication at school:  School Nurse  School Staff (Specify):

<table>
<thead>
<tr>
<th>Medication</th>
<th>Taken at Home or School?</th>
<th>Dose</th>
<th>Route</th>
<th>Time</th>
<th>Side Effects</th>
</tr>
</thead>
</table>

Location of routine medication:

**SCHOOL NURSE**

Individualized Healthcare Plan/Emergency Care Plan (this form) distributed to ‘need to know’ staff:

- Front office/admin
- Teacher(s)
- Transportation
- Other (specify):

School Nurse Signature:

**Date:**