Individualized Healthcare Plan/Emergency Action Plan			School Year:	Picture
STUDENT INFORMATION				
Student:	DOB:	Grade:	School:	
Parent:	Phone:		Email:	
Physician:	Phone:		Fax or email:	
School Nurse:	School Phone:		Fax or email:	

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

If you see this	*Do This*

EMERGENCY PROTOCOL	Expected Behavior After Event	Follow Up
□ Call 911 □ Transport to: □ Call parent or emergency contact □ Administer emergency medications □ Other (specify):	□ Tiredness □ Weakness □ Sleeping, difficult to arouse □ Regular breathing □ Other (specify):	• 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:

Student:	DOB:	Grade:

EMERGENCY OR RESCUE MEDICATIONS

If medication is ordered **must** submit separate medication authorization completed with parent and healthcare provider signature.

This form alone is **not** a valid medication authorization.

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

Medication	Dose	Route	Time	Side Effects

Location of rescue medication:

ROUTINE MEDICATIONS (see above statement)

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

Medication	Taken at Home or School?	Dose	Route	Time	Side Effects

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:

Addendum: