

Harrison County School Health Clinic

***EMERGENCY
ACTION
PLAN***

Confidential

Student Name: _____

Date of Birth: _____

Date of Implementation: _____

This EAP is appropriate for use for ONE YEAR from the date of implementation.

EMERGENCY ACTION PLAN

Harrison County School Health Clinic

STUDENT INFORMATION

Student Name: _____ DOB _____ YEAR _____

SCHOOL: _____ GRADE: _____ TEACHER: _____

Student's address: _____ PHONE: _____

Medication Allergies or OTHER Allergies: _____

Mother's/ Guardian's Name: _____

Phone: (H) _____ (C) _____ (W) _____

Father's / Guardian's Name: _____

Phone: (H) _____ (C) _____ (W) _____

Emergency Contact #1: _____

Phone: _____

Relationship: _____

Emergency Contact #2: _____

Phone: _____

Relationship: _____

Provider's Name: _____

Date last seen: _____

Phone: _____

Provider's Address: _____

HEALTH CONDITION: (Diabetes, Asthma, Seizures, Severe Allergy, Other)	Medications	Care needed at school. PLAN INITIATED

Other information or instructions: _____

Nurse Signature	Person Interviewed	Date: Initial Interview and yearly updates

Harrison County School Health Clinic
EMERGENCY ACTION PLAN FOR ASTHMA

Student: _____ **Date of Birth:** _____

School: _____ **School Year:** _____

Triggers (Check all that apply to this child)

- | | | |
|---------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Animals | <input type="checkbox"/> Molds |
| <input type="checkbox"/> Fumes | <input type="checkbox"/> Carpet | <input type="checkbox"/> Respiratory Infection(Cold/Flu) |
| <input type="checkbox"/> Strong Odors | <input type="checkbox"/> Pollen | <input type="checkbox"/> Change in Weather/temperature |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Smoke | <input type="checkbox"/> Trees/Grass/Plants/Pollen |

Foods (Specify): _____

Other (Specify): _____

Signs and Symptoms student will likely exhibit (Check all that apply)

- Coughing
- Labored/Difficulty breathing
- Wheezing
- Chest tightness

Recommended Preventative Measures and Interventions:

- Avoid known irritants.
- Encourage student to assume position of comfort.
- Offer warm liquid to drink.
- Encourage slow, deep breathing.
- Cover nose and mouth to block cold air. (example: use scarf during winter months)
- The use of prescribed inhalers or nebulizers.

List name of inhaler or nebulizer to be kept at school: _____

***Medication will be given as indicated by your child's doctor, so a prescribed medication form must be completed by the Health Care Provider and attached to the Emergency Action Plan.

Emergency Plan of Action

- If students color becomes pale, cyanotic (blue), or ashen: CALL 911 immediately
 - If students breathing stops, CPR certified staff should initiate rescue breathing (and CPR if necessary).
 - Contact parent/guardian or emergency contact immediately. (See student information page)
 - Other (Please specify) _____
- _____
- _____

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____

Harrison County School Health Clinic
Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____ School Year: _____ Date form received: _____

I acknowledge receipt of this Physician's Statement and Parent Authorization:

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Student Name _____ Date of Birth _____

Name of Medication: _____

Reason for Medication: _____

Allergies: _____

Form of Medication: Tablet/Capsule Liquid Inhaler Injection Nebulizer Other _____

Instructions (Schedule and dose to be given at school): _____

Start Date: Date Form Received Other _____

Stop Date: End of School Year Other date/duration: _____

For episodic/emergency events only

Restrictions and/or important side effects: NO Restrictions

Yes (please describe): _____

Special Storage Requirements: None Refrigerate Other: _____

Physician Signature _____ Physician's Name _____

Date _____ Phone _____ Address _____

FOR SELF ADMINISTRATION ONLY

Pursuant to KRS 158.832 to KRS 158-836 Harrison County Schools permits a student to possess and self-administer asthma, diabetes or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.

This student has been instructed on self-administration of this medication: (to be completed for asthmatic, diabetic, or severe allergic reaction (anaphylaxis) ONLY):

NO Supervision required Supervision NOT required

This student may carry this medication: YES NO

Please indicate if you have provided additional information:

On the back side of this form As an attachment

Physician Signature _____ Date _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ to receive the above stated medication at school according to the standard school policy. I release the Harrison County School Board and its employees from any claims or liability connected with its reliance on the permission.

(Parent/Guardian to bring the medication in its original container.)

Date _____ Name: _____ Signature _____

Relationship to Child: _____

Home Phone: _____ Work Phone: _____

Other Emergency Contact Name: _____ Phone: _____