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

OTHER Condition Emergency Action Plan

Name	Date of Birth

Physician's Name:	Phone:
Address:	
Date Last Seen:	Hospital of Choice:
What type(s) of MEDICAL CONDITION(s) does your child have?	
Describe each type of EPISODE or symptoms that school staff need to be aware of that may be signs that the student is having difficulty:	
How often do they occur?	
How long do they last?	
Any warning signs or behavior changes prior to episode(s)?	
Any special needs or adaptive or safety equipment (i.e., helmet) needed at school?	

Other information or instructions:

Person Interviewed: _____

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: _____