EMERGENCY ACTION PLAN (Other conditions)

STUDENT _____ DOB _____ SCHOOL _____

GRADE/TEACHER _____ SCHOOL YEAR _____

PARENT/LEGAL GUARDIAN _____

HOME PHONE_____WORK PHONE_____ CELL PHONE _____

PHYSICIAN _____ PHONE _____

HEART CONDITION: ☐ **- Yes** ☐ **- No**

- If yes, is activity limited? ☐ **- Yes** ☐ **- No**

  If yes, please list restrictions:_____

- Is your child on medication for this heart condition? ☐ **- Yes** ☐ **- No**

  ☐ - At home? ☐ - At school? ***

- List names of all medications outside of school hours:_____

  _____

ORTHOPEDIC CONDITION: ☐ **- Yes** ☐ **- No**

- If yes, is activity limited? ☐ **- Yes** ☐ **- No**
  If yes, please list restrictions:_____

  _____

  _____

- Is your child on medication for this condition? ☐ **- Yes** ☐ **- No**

  ☐ - At home? ☐ - At school? ***

- Please list names of all medications outside of school hours:_____

  _____

OTHER HEALTH CONDITION: ☐ **- Yes** ☐ **- No**

- If yes, briefly describe:_____

  _____

  _____

- Please list any necessary procedures/measures to be taken during school hours:_____

  _____

  _____

**If special accommodations are recommended, please specify: _____.

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PLEASE NOTE: If your student needs medication during the school day, a **Medication Authorization form** must be completed every school year by **you *and* your child's physician**. These forms may be obtained from your school secretary.

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STUDENT NAME _____

EMERGENCY ACTION PLAN

(For School Staff Use)

MEDICAL CONDITION _____

_____

_____

TREATMENT DURING SCHOOL HOURS _____

_____

_____

SIGNS OF EMERGENCY _____

_____

_____

ACTIONS FOR SCHOOL PERSONNEL TO TAKE _____

_____

_____

ADDITIONAL INSTRUCTIONS _____

_____

_____

PHYSICIAN SIGNATURE _____ DATE _____

To be Completed by the Parent:

I give permission for my child, _____ , to receive care for the medical condition listed above by designated school staff . I also allow school staff and/or the school nurse to share information regarding this treatment with my student's physician and their office if necessary. (Permission is good for one year.)

PARENT/GUARDIAN SIGNATURE _____ DATE _____

SCHOOL NURSE _____ DATE _____