School Year: _____

STUDENT
EMERGENCY ACTION PLAN

Student Name: _____ Date of Birth: _____

School: _____Grade: _____ Teacher: _____

Allergies: _____ Bus Rider: □Yes □ No Bus #: AM _____ PM _____

Emergency Information	
Parent/Guardian Name:	
Primary Phone Number:	Other:
Physician Name:	Phone Number:
Emergency Contact: 1._____Phone:_____ 2._____Phone:_____	
HEALTH CONDITION (list):	
Physician Orders provided to school: □ Yes □ No □ Diabetes □ Seizures □ G-Tube □ Catheterization □ Epi Pen □ Other _____	
Emergency Medications to be given (medications administered at school require a medication authorization form): _____	
Condition Details (History/Symptoms/Triggers): _____ _____ _____ _____	
Treatment at School /Actions to be taken: _____ _____ _____ _____	
Additional Comments: _____ _____	

BACK

REVIEWED BY: _____ _____

Nurse Date

SH-752 EP/CJ 6/2024

School Year: _____

This information will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your student daily.

□ I, the undersigned Parent/Guardian of _____, **authorize a School Nurse or "trained staff member"** to administer medication or treatment to my student according to the Physician's instructions or medical management plan. I give permission to the school nurse or another qualified health care professional to collaborate with my child's physician/healthcare provider as needed. I agree to provide all equipment, supplies, medication, or other items necessary to provide the appropriate care to my student. I agree to notify the School Nurse immediately if there is any change in the student's status or Physician's orders. The School Nurse reserves the right to monitor the student periodically throughout the year.

□I, the undersigned Parent/Guardian agree to pick up any unused medication within two weeks of the last day of school, or it will be destroyed. The School Nurse is not always in the building and trains non-medical school staff to administer medication (routine & emergency) and to assist with medical treatment as outlined in your student's emergency action plan. Additionally, the undersigned agrees to hold the school personnel harmless for any injuries resulting from the emergency care unless the injury was caused by the trained staff's negligence.

Parent/Guardian Signature: _____

Date: _____

NURSE USE ONLY

□ Teacher Copy	□ Cafeteria Copy	□ Med Book/ Cumulative Copy	□ Transportation

REVIEWED BY: _____ _____

Nurse Date

SH-752 EP/CJ 6/2024