## Individualized Healthcare Plan/Emergency Care Plan

### Student Information

<table>
<thead>
<tr>
<th>Student:</th>
<th>DOB:</th>
<th>Grade:</th>
<th>School:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>Phone:</td>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Physician:</td>
<td>Phone:</td>
<td>Fax or email:</td>
<td></td>
</tr>
<tr>
<td>School Nurse:</td>
<td>School Phone:</td>
<td>Fax or email:</td>
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</tbody>
</table>

### 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:**

### Emergency Care Plan

If you see this

<table>
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<tr>
<th>Do This</th>
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#### EMERGENCY PROTOCOL

- □ Call 911
- □ Transport to:
- □ Call parent or emergency contact
- □ Administer emergency medications
- □ Other (specify):

#### Expected Behavior After Event

- □ Tiredness
- □ Weakness
- □ Sleeping, difficult to arouse
- □ Regular breathing
- □ Other (specify):

#### Follow Up

- • Document
- • Call School Nurse
- • Other:

### Special Considerations

Special Health Care Needs: (Problems we need to deal with at school: Feedings? Oxygen? Respiratory problems?)

### 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)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Time</th>
<th>Side Effects</th>
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Location of rescue medication:

### ROUTINE MEDICATIONS (see above statement)

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Taken at Home or School?</th>
<th>Dose</th>
<th>Route</th>
<th>Time</th>
<th>Side Effects</th>
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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: