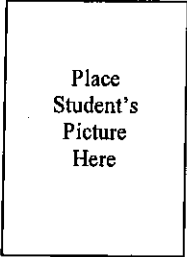


Emergency Healthcare Plan



Name: _____ DOB: _____

Teacher: _____ Grade: _____

Medical Condition: _____

Symptoms of Condition: _____

Action/Treatment: _____

Parent/Guardian/Relative Caregiver: _____ Phone: _____

Parent/Guardian/Relative Caregiver: _____ Phone: _____

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

If symptoms of health problems above occur, the school nurse will assess the student and institute the prescribed action/treatment. The school nurse or designee will contact the parent/guardian/Relative Caregiver of the student. If a parent/guardian/Relative Caregiver cannot be reached, the emergency contact person will be called. Emergency personnel may be given a copy of this form.

Parent/Guardian/Relative Caregiver Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Date _____

Physician's Approval of Procedure

The licensed healthcare provider will approve or authorize the procedure that is to be used in the school. The authorization will include the following information:

Name of Child _____ Birth Date _____

Physical condition for which procedure is authorized _____

Name of procedure to be performed _____

Precautions, possible untoward reactions, and interventions _____

Time schedule and/or indication for the procedure _____

Physician's Signature _____

Address _____

Phone Number _____ Date _____

**Parent/Guardian/Relative Caregiver's Request Form for
School to Provide
Specialized Nursing Treatment or Procedure**

Permission and directions should be renewed at the start of each school year.

Child's Name _____ Phone No. _____

Physician's Name _____ Phone No. _____

Address _____

I (We) request the following health care procedure to be done:

This procedure has been approved by the child's licensed healthcare provider, (Physician's Name) _____.* I (We) will notify the school immediately if there is a change in licensed healthcare provider, health status of child (Child's Name) _____, or change in procedures.

I understand the school nurse may need to speak with the prescribing healthcare provider. I grant permission for the sharing of information relative to my child's procedure and the related diagnosis.

Signature of Parent/guardian/Relative Caregiver(s) _____

Address _____

Home Phone _____ Work Phone _____

Attach document to this effect.