Emergency Healthcare Plan

Place Student's Picture Here

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.