

<b>Emergency action plan</b>				School year:	Picture
Utah Department of Health and Human Services					
<b>Student information</b>					
Student name:	Date of birth:	Grade:	School:		
Parent name:	Phone:	Email:			
Physician name:	Phone:	Fax or email:			
School nurse name:	School phone:	Fax or email:			
<b>Brief medical history</b>					
Medical diagnosis:					
Medical history:					
Baseline status (healthy? decreased immunity?):					
<b>Parent or guardian:</b> complete the above section and sign below. Get a signature from your child's healthcare provider and return this form to the school nurse. No accommodations can be made until signed this form and medication order (if applicable) are on file with the school.					
As parent/guardian of this student, I give permission for my student'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 my responsibility to notify the school nurse of any change in my student's health status or medication order. I understand it is my responsibility to maintain necessary supplies, medications, and equipment.					
Parent signature:				Date:	
<b>Emergency action plan</b>					
<b>If you see this</b>			<b>Do this</b>		
<b>Emergency protocol</b>		<b>Expected behavior after event</b>	<b>Follow up</b>		
<input type="checkbox"/> Call 911 <input type="checkbox"/> Transport to: <input type="checkbox"/> Call parent or emergency contact <input type="checkbox"/> Administer emergency medications <input type="checkbox"/> Other (specify):		<input type="checkbox"/> Tiredness <input type="checkbox"/> Weakness <input type="checkbox"/> Sleeping, difficult to arouse <input type="checkbox"/> Regular breathing <input type="checkbox"/> Other (specify):	Document Call school nurse Other:		
<b>Special considerations</b>					
Special healthcare needs (problems we need to deal with at school: feedings? oxygen? respiratory problems?):					
Special considerations and precautions:					
Transportation-special care required? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify:					

Student:		DOB:		Grade:	
<b>Emergency or rescue medications</b> If medication is ordered, a separate medication authorization form <b>must</b> also be completed, signed, and returned to the school.					
<b>This form alone is NOT a valid medication authorization (separate medication authorization form is required)</b>					
Person to give rescue medication: <input type="checkbox"/> School nurse <input type="checkbox"/> Parent <input type="checkbox"/> EMS <input type="checkbox"/> Volunteer(s) (Specify): _____					
Medication	Dose	Route	Time	Side effects	
Location of rescue medication: _____					
<b>Routine medications (see above statement)</b>					
Person to give routine medication at school: <input type="checkbox"/> School nurse <input type="checkbox"/> School staff (Specify): _____					
Medication	Taken at home or school?	Dose	Route	Time	Side effects
Location of routine medication: _____					
<b>School nurse</b>					
Emergency action plan distributed to need-to-know staff: <input type="checkbox"/> Front office/admin <input type="checkbox"/> Teacher(s) <input type="checkbox"/> Transportation <input type="checkbox"/> Other (specify): _____					
School nurse signature:			Date:		

Addendum: