

**EMERGENCY ACTION PLAN (Other conditions)**

STUDENT \_\_\_\_\_ DOB \_\_\_\_\_ SCHOOL \_\_\_\_\_

GRADE/TEACHER \_\_\_\_\_ SCHOOL YEAR \_\_\_\_\_

PARENT/LEGAL GUARDIAN \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

**HEART CONDITION:**             - Yes         - No

• If yes, is activity limited?     - Yes         - No

If yes, please list restrictions: \_\_\_\_\_

• Is your child on medication for this heart condition?     - Yes         - No

- At home?             - At school? \*\*\*

• List names of all medications outside of school hours: \_\_\_\_\_

\_\_\_\_\_

**ORTHOPEdic CONDITION:**     - Yes         - No

• If yes, is activity limited?     - Yes         - No

If yes, please list restrictions: \_\_\_\_\_

\_\_\_\_\_

• Is your child on medication for this condition?     - Yes         - No

- At home?             - At school? \*\*\*

• Please list names of all medications outside of school hours: \_\_\_\_\_

\_\_\_\_\_

**OTHER HEALTH CONDITION:**     - Yes         - No

• If yes, briefly describe: \_\_\_\_\_

\_\_\_\_\_

• Please list any necessary procedures/measures to be taken during school hours: \_\_\_\_\_

\_\_\_\_\_

\*\*If special accommodations are recommended, please specify: \_\_\_\_\_

**PLEASE NOTE:** If your student needs medication during the school day, a **Medication Authorization form** must be completed every school year by **you and your child's physician**. These forms may be obtained from your school secretary.

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STUDENT NAME \_\_\_\_\_

**EMERGENCY ACTION PLAN**  
(For School Staff Use)

MEDICAL CONDITION \_\_\_\_\_

\_\_\_\_\_

TREATMENT DURING SCHOOL HOURS \_\_\_\_\_

\_\_\_\_\_

SIGNS OF EMERGENCY \_\_\_\_\_

\_\_\_\_\_

ACTIONS FOR SCHOOL PERSONNEL TO TAKE \_\_\_\_\_

\_\_\_\_\_

ADDITIONAL INSTRUCTIONS \_\_\_\_\_

\_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**To be Completed by the Parent:**

I give permission for my child, \_\_\_\_\_, to receive care for the medical condition listed above by designated school staff. I also allow school staff and/or the school nurse to share information regarding this treatment with my student's physician and their office if necessary. (Permission is good for one year.)

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SCHOOL NURSE \_\_\_\_\_ DATE \_\_\_\_\_