Harrison County School Health Clinic

EMERGENCY ACTION PLAN

Confidential

Student Name:______________________________

Date of Birth:______________________________

Date of Implementation:______________________

This EAP is appropriate for use for ONE YEAR from the date of implementation.

EMERGENCY ACTION PLAN

Harrison County School Health Clinic
STUDENT INFORMATION

Student Name:________________________**DOB**____________**YEAR**______
SCHOOL:________________________GRADE:______TEACHER:__________
Student's address:________________________PHONE:________________
Medication Allergies or OTHER Allergies: ________________________
____

Mother's/ Guardian's Name:________________________________
Phone: (H)______________**(C)**______________**(W)**______________
Father's / Guardian's Name: ________________________________
Phone:(H)______________**(C)**______________**(W)**______________

Emergency Contact #1: ________________________________
Phone:________________________________
Relationship: ________________________________
Emergency Contact #2:________________________________
Phone: ________________________________
Relationship: ________________________________

Provider's Name: ________________________________
Date last seen: ________________________________
Phone: ________________________________
Provider's Address:________________________________

HEALTH CONDITION: (Diabetes, Asthma, Seizures, Severe Allergy, Other	Medications	Care needed at school. PLAN INITIATED

Other information or instructions: ________________________________
____

Nurse Signature	Person Interviewed	Date: Initial Interview and yearly updates

Harrison County School Health Clinic
EMERGENCY ACTION PLAN FOR ASTHMA

Student:_________________________________ **Date of Birth:**________________

School:_________________________________ **School Year:**________________

Triggers (Check all that apply to this child)

___Exercise	___Animals	___Molds
___Fumes	___Carpet	___Respiratory Infection(Cold/Flu)
___Strong Odors	___Pollen	___Change in Weather/temperature
___Dust	___Smoke	___Trees/Grass/Plants/Pollen

Foods (Specify):____
Other (Specify):____

Signs and Symptoms student will likely exhibit (Check all that apply)

___Coughing
___Labored/Difficulty breathing
___Wheezing
___Chest tightness

Recommended Preventative Measures and Interventions:

-Avoid known irritants.
-Encourage student to assume position of comfort.
-Offer warm liquid to drink.
-Encourage slow, deep breathing.
-Cover nose and mouth to block cold air. (example: use scarf during winter months)
-The use of prescribed inhalers or nebulizers.
List name of inhaler or nebulizer to be kept at school:____________________________
***Medication will be given as indicated by your child's doctor, so a prescribed medication form must be completed by the Health Care Provider and attached to the Emergency Action Plan.

Emergency Plan of Action

-If students color becomes pale, cyanotic (blue), or ashen: CALL 911 immediately
-If students breathing stops, CPR certified staff should initiate rescue breathing (and CPR if necessary).
-Contact parent/guardian or emergency contact immediately. (See student information page)
-Other (Please specify)____
____
____

Parent/Guardian Signature:_________________________________ Date:_______

School Nurse Signature:_________________________________ Date:_______

Harrison County School Health Clinic
Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: ____________________ School Year: ____________ Date form received: ______________

I acknowledge receipt of this Physician's Statement and Parent Authorization: ______________

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Student Name ____________________________ **Date of Birth** ____________________________

Name of Medication: ____

Reason for Medication: ____

Allergies: ____

Form of Medication: □ Tablet/Capsule □Liquid □Inhaler □Injection □Nebulizer □Other ______________

Instructions (Schedule and dose to be given at school): ______________________________

____

Start Date: □ Date Form Received □ Other ______________________________

Stop Date: □ End of School Year □ Other date/duration: ______________________

□**For episodic/emergency events only**

Restrictions and/or important side effects: □ NO Restrictions

□Yes (please describe) : ____

____

Special Storage Requirements: □ None □ Refrigerate □ Other: ______________________

Physician Signature ________________________ Physician's Name ______________

Date ______________ Phone ______________ Address ______________________

*****FOR SELF ADMINISTRATION ONLY*****

Pursuant to KRS 158.832 to KRS 158-836 Harrison County Schools permits a student to possess and self-administer asthma, diabetes or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.

This student has been instructed on self-administration of this medication: **(to be completed for asthmatic, diabetic, or severe allergic reaction (anaphylaxis) ONLY):**

□ NO □ Supervision required □ Supervision NOT required

This student may carry this medication: □ YES □ NO

Please indicate if you have provided additional information:

□ On the back side of this form □ As an attachment

Physician Signature ______________________________ Date ______________________

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) ______________________ to receive the above stated medication at school according to the standard school policy. I release the **Harrison County School Board** and its employees from any claims or liability connected with its reliance on the permission.
(Parent/Guardian to bring the medication in its original container.)

Date __________ Name: ____________________ Signature ______________________________

Relationship to Child: ____

Home Phone: ____________________ Work Phone: ______________________________

Other Emergency Contact Name: ______________________ Phone: ______________________