Hutchinson Public and Parochial Schools Health Services

Emergency Care Plan/Individual Health Plan

School Year _____

Student Name _____ DOB_____ Grade ____ Teacher/Room _____

Allergy (check all that apply)

- ☐ Peanuts_____
- ☐ Tree Nuts_____
- ☐ Shellfish_____
- ☐ Fish_____
- ☐ Insect Bites/Stings:_____
- ☐ Latex
- ☐ Metal/Nickel
- ☐ Sulfa
- ☐ Eggs_____
- ☐ Dairy_____
- ☐ Wheat
- ☐ Soy
- ☐ Other_____
- ☐ Other_____

Medical Condition (check all that apply)

- ☐ Seizure
- ☐ Diabetes (see diabetes plan)
- ☐ Asthma (see asthma action plan)
- ☐ Heart Disease
- ☐ Shunt
- ☐ Headache
- ☐ Bowel Issue:_____
- ☐ Bladder Issue:_____
- ☐ Hearing loss
- ☐ Feeding tube
- ☐ ADHD_____
- ☐ Mental Health/Behavior Diagnosis:_____
- ☐ Pacemaker/electrical stimulator
- ☐ Other_____
- ☐ Other_____

Signs/Symptoms (check all that apply)

Mouth

- ☐ Itching
- ☐ Tingling
- ☐ Swelling of lips
- ☐ Swelling of tongue
- ☐ Swelling of mouth
- ☐ _____
- ☐ All of the above

Skin

- ☐ Hives
- ☐ Itchy rash
- ☐ Swelling of face
- ☐ Swelling of arms/legs
- ☐ Swelling at site of bite
- ☐ _____
- ☐ All of the above

Gastrointestinal

- ☐ Nausea
- ☐ Cramps
- ☐ Vomiting
- ☐ Diarrhea
- ☐ _____

Respiratory

- ☐ Tightening of throat
- ☐ Hoarseness
- ☐ Hacking cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ _____
- ☐ All of the above

Treatment/Action (check all that apply)

- ☒ Administer medication(s) as ordered
- ☒ Call 911 as needed
- ☒ Administer CPR as needed
- ☒ Contact parent/guardian for _____
- ☒ Contact LSN for _____
- ☐ Check pulse and blood pressure
- ☐ Contact parent if blow to head
- ☐ Place student on floor on their side
- ☐ Monitor and record seizure activity and duration
- ☐ Limit activities as indicated by MD
- ☐ Allow student to use bathroom in Health Office
- ☐ Toilet every _____
- ☐ Preferred classroom seating _____
- ☐ Preferred cafeteria seating
- ☐ _____
- ☐ _____

Heart

- ☐ Weak pulse
- ☐ Thready pulse
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Pale
- ☐ Cyanosis
- ☐ Chest pain
- ☐ _____

Seizure

- ☐ Fumbling
- ☐ Blank staring
- ☐ Confused
- ☐ Wandering
- ☐ Partial Simple
- ☐ Partial Complex
- ☐ Tonic-Clonic
- ☐ _____

Nursing Diagnoses

- ☐ Potential for life-threatening condition
- ☐ Potential for altered performance due to condition or related absences

Goals

- ☐ Student will participate in regular school activities with modifications as needed
- ☐ Promote understanding of condition, prevention and treatment
- ☐ Maximize students ability to learn and participate in school
- ☐ Maximize self-advocacy, and self-esteem
- ☐ _____

Equipment

- ☐ Wheelchair
- ☐ Stroller
- ☐ Walker/cane
- ☐ Hoyer lift
- ☐ Stander
- ☐ Ramps
- ☐ Toilet riser

Supplies/adaptations

- ☐ Incontinent pads
- ☐ AFO/braces
- ☐ Other
- ☐ Slide board
- ☐ Hearing aids **R L**
- ☐ Gait belt

Physician Orders

Student Name _____ DOB _____Grade ____ Teacher/Room _____

Epinephrine (Inject intramuscular) ☐ Epi-Pen 0.3mg ☐ Epi-Pen Jr. 0.15mg ☐ Twinject 0.3mg ☐ Twinject 0.15mg ☐ ***This student may carry his/her Epi-Pen, and is capable and responsible for self-administering this medication***	Antihistamines ☐ Benadryl_____ ☐ Diphenhydramine_____ ☐ Zyrtec_____ ☐ Claritin_____ ☐ Other_____

Antiepileptics (for seizure longer than _____min)	Daily Medications	Dose	Give by mouth _____ tab(s)/cap(s)
☐ Diastat Acudial 5 mg	☐ Adderall	☐ 0.1 mg	☐ In the morning
☐ Diastat Acudial 7.5mg	☐ Clonidine	☐ 5 mg	☐ At lunch
☐ Diastat Acudial 10mg	☐ Dexedrine	☐ 10 mg	☐ In the afternoon
☐ _____	☐ Ritalin (Methylphenidate)	☐ 15 mg	☐ _____
☐ _____	☐ Guanfacine (Tenex)	☐ 20 mg	☐ _____
	☐ _____	☐ _____	
	☐ _____	☐ _____	

Inhalers
- ☐ _____
- ☐ _____
- ☐ ***This student may carry his/her inhaler, and is capable and responsible for self-administering this medication***

Start Date	Stop Date	Reason for medication	Instructions

Tube Feeding	Formula Type	Amount	Infusion Rate	Admin time	Special Instructions
☐ J Tube ☐ G Tube					

Physician Signature	Date	Clinic and phone number

Comments

Emergency Contacts

Name	Relationship	Phone #1	Phone #2
1.			
2.			

******I understand by signing this form, I authorize the school to administer the medication(s) according to standard school policy. I give permission for the LSN or building nurse to contact my child's heath care provider regarding this plan and/or medication, and to communicate with my child's teachers, bus company, athletic director and/or other school personnel regarding my child's health condition(s) and medication(s) as deemed necessary. I release school personnel from liability in the event of adverse reactions resulting from this medication. I understand that administration of medication may not necessarily be done by a nurse. I authorize my child to self-administer his/her inhaler if deemed appropriate by LSN and he/she is at Middle or High School level.***

Parent/Guardian signature _____ Date _____

LSN signature _____ Date _____