Appendix A

Individualized Health Care Plans
Emergency Plan Procedure Information Sheet Daily Log
Medical Order Forms
Parent Authorization Form
Components of an Individualized Health care Plan

Who should have an Individualized Health care Plan (IHP)?

Students with mild to severe health care needs and require frequent nursing services at school should have an IHP.

What is the purpose of an IHP?

The IHP helps assure consistent, safe health care for the student, protects the school nurse in legal proceedings, and provides documentation regarding the extent of services provided. Each IHP should be individualized to meet the needs of the student.

What should the IHP include?

The IHP should include the following four components:

1. Nursing assessment
2. Nursing diagnoses
3. Nursing interventions
4. Expected outcomes

Each IHP may include additional components to meet the needs of the student. The IHP should be revised when the student’s physical condition or care changes. Each IHP should be consistent with minimum standards of care.

IHPs also should address:

- Physical education classes, if appropriate
- Special activities (i.e., swimming)
- Field trips
- Classroom parties
- Off-campus work opportunities
- Bus transportation
- Medical equipment, supplies, and services

Who should develop and sign the IHP?

Oklahoma Guidelines for Health care Procedures in Schools
The following individuals should help develop and then sign the IHP:

- Parents/Guardians
- Student
- Medical provider (optional)
- Registered school nurse

Parents or legal guardians must authorize, in writing, care provided for their minor children.

Medical providers (physicians, nurse practitioners, physician assistants) must provide written orders for medical treatments provided at school.

**How often should the IHP be updated?**

The IHP should be updated as appropriate and revised at least annually (i.e., at least once each school year) or after significant changes occur in the student’s health status.

**What is the Emergency Care Plan or Emergency Action Plan?**

The Emergency Care Plan (ECP) is required when a chronic condition has the potential to result in a medical emergency. The ECP is a component of the IHP.
Components of an Individualized Health Care Plan (IHP)

1. **Assessment**

   The assessment provides the background information for the IHP and includes:
   
   - Health history
   - Current health status
   - Self-care skills/needs
   - Psychosocial status
   - Health issues related to learning

2. **Nursing Diagnosis**

   A nursing diagnosis summarizes the current health status of the student based on the student’s response to the health condition and defines what the school nurse can contribute as an autonomous practitioner.

3. **Goals**

   Goals are clear, concise, realistic descriptions of desired outcomes. They may be short-term or long-term but they must be measurable.

4. **Nursing Interventions**

   A nursing intervention is any treatment performed to reach a goal or desired outcome.

5. **Student Outcome**

   An outcome describes what the student is expected to do. It must be realistic and measurable.

6. **Evaluation**

   The evaluation consists of periodically reviewing the student’s goals and outcomes; comparing actual versus predicted outcomes; reviewing the interventions; and, if necessary, modifying the IHP. Evaluations also should occur when the student’s health status changes significantly or when the medical provider changes the student’s prescribed treatment or medications.

Oklahoma Guidelines for Healthcare Procedures in Schools
Sources:


Individualized Health care Plan (IHP)

Student: 

Name 

Date of Birth

Prepared By: 

School Nurse or (Title) 

Date

Approved By: 

Parent/Guardian(s) 

Date

Parent/Guardian(s) 

Date

Approved By: 

Student 

Date

Approved By: 

Medical Provider (optional) 

Date

Next Review & Revision Due: 

Oklahoma Guidelines for Healthcare Procedures in Schools
Individualized Health care Plan

Demographics

Student Name ___________________ Birth Date ___________________

Home Address ___________________ Home Phone ________________

Parent/Guardian ___________________ Phone ________________

Parent/Guardian ___________________ Phone ________________

Caregiver ___________________

Language Spoken at Home _________________

Emergency Contacts:

_________________ _______________ _______________
Name Relationship Phone

_________________ _______________ _______________
Name Relationship Phone

Oklahoma Guidelines for Healthcare Procedures in Schools
Medical Care

Primary Health care Provider _________________ Phone _________________

Specialty Health care Provider _________________ Phone _________________

Health History

Brief Health History

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Special Health care Needs __________________________________________________________________
____________________________________________________________________

Oklahoma Guidelines for Healthcare Procedures in Schools
Current Health Status (Baseline status, e.g., skin color/integrity, vital signs, mobility)

Student Participation in Care

Health Issues Related to Learning

Activity Considerations (physical education, field trips, extracurricular activities)

Equipment, Supplies, Services

Oklahoma Guidelines for Healthcare Procedures in Schools
Other considerations

Oklahoma Guidelines for Healthcare Procedures in Schools
Medication & Dietary Needs

Current Medications (dose, route, time)

__________________________________________________________

__________________________________________________________

__________________________________________________________

Special Dietary Requirements

__________________________________________________________

__________________________________________________________

__________________________________________________________

Allergies (include type of reaction)

__________________________________________________________

__________________________________________________________

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# Individualized Health Care Plan - Components

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<tr>
<th>Assessment Data</th>
<th>Nursing Diagnosis</th>
<th>Goals</th>
<th>Nursing Interventions</th>
<th>Expected Outcomes</th>
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Oklahoma Guidelines for Healthcare Procedures in Schools
Procedures

Procedure ______________________________________________________

Frequency_________________________ Times________________________

Position of student during procedure __________________________________

Ability of student to assist/perform procedure __________________________

Location for procedure _____________________________________________

Equipment needed

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

Procedural considerations & precautions

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

Staff qualified to assist with procedure

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
Daily Log

Student Name_________________________ Class/Grade _____

Procedure ____________________________________________

Parent________________________________________Phone ________________

<table>
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<tr>
<th>Date/Time</th>
<th>Procedure notes</th>
<th>Observations</th>
<th>Time for Prep, Proc, Doc</th>
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Oklahoma Guidelines for Healthcare Procedures in Schools
Emergency Care Plan (or Emergency Action Plan)

Student Name ___________________________  Class/Grade ____________
Parent/Guardian ___________________________  Phone ________________
Parent/Guardian ___________________________  Phone ________________
Health care Provider _________________________  Phone ________________

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In an emergency occurs:

1. Stay with child
2. Call or have someone else call the school nurse
3. If the school nurse is not available, the following staff members are trained to initiate the emergency care plan.

__________________________________
__________________________________
__________________________________

Oklahoma Guidelines for Healthcare Procedures in Schools
Consent for Administration of Special Health Care Procedures

Student___________________________________________Birth Date___________School Year ________

Primary Diagnosis___________________________________________ICD-10 ____________

Diagnosis________________________ICD-10________Diagnosis________________________ICD-10 ____________

This form is used for specialized procedures which may include, but not be limited to administration of oxygen, urinary catheterization or wound care procedures which may be needed and provided for a student while he/she attends school. The procedure(s) may be performed by school personnel trained and supervised by a Licensed School Nurse.

............................................................................................................................................

Parent/Guardian Authorization

I authorize the school nurse to contact the licensed provider as needed concerning this medication/s.

Provider/Clinic__________________________Phone # __________Fax # __________________________

- I understand that parent/guardian authorization is required for any prescription medication to be given at school. Prescription medications must have a physician or licensed authorization.

- I understand that I must provide all medication(s) and equipment for the procedure(s) below.

- I understand all medications must be provided with an accurately labeled prescription container. (Please ask your health provider for the medication to be divided into two containers-one for school, & one for home) Nonprescription medications must be in an original container with label and directions.

- I will notify the school immediately if my child’s health status changes or there is a cancellation of the procedure(s).

- The medication may not necessarily be administered by a school nurse. The medications may be administered by school personnel trained and supervised by a licensed school nurse.

- I have read this Parent/Guardian Authorization section and agree to the instructions it provides.

Parent/Guardian Signature__________________________Date _______________

............................................................................................................................................
**Physician's Orders**

Procedure __________________________________________________________

Instruction __________________________________________________________

Time/interval procedure is to be done ______________________________________

Amount (if applicable) ___________________________________________________

Precautions and/or adverse reactions _______________________________________

_____________________________________________________________________

**Physician's Signature** ____________________________  Date _________________

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<td>LSN Signature _______________________  Date _________________</td>
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<td>Name of Staff Routing __________________ Date _________________</td>
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Please check off who was routed this form
- [ ] Student File
- [ ] IEP Manager
- [ ] Building Nurse
- [ ] Other

Consent for Administration of Special Health Care Procedures
Students with Special Health Care Needs
TRANSPORTATION PLAN

Date: ____________________________ Is this Child on an IEP? □ Yes □ No

Student’s Name ____________________________

Route AM □ PM □ Driver: ____________________________

Address ____________________________

Parent/Guardians ____________________________

Home Telephone ____________________________

Dad Daytime Phone ____________________________ Mom Daytime Phone ____________________________

Babysitter’s Name & Phone ____________________________

School ____________________________ Teacher’s Name ____________________________

School’s Phone ____________________________ Teacher’s Aide ____________________________

Disability/Diagnosis ____________________________

Medications ____________________________ Side Effects ____________________________

Mode of Transportation □ wheelchair □ car seat □ seat belt □ chest harness

Walks up bus stairs independently □ No □ Yes

Student positioning and handling requirement: Seat # ____________ Wheelchair Position # ____________

List student’s/driver’s method of communication ____________________________

List any behavioral difficulties student displays (attach IEP behavioral goals) ____________________________

List equipment that must be transported on bus including oxygen, life sustaining equipment, wheelchair equipment, etc ____________________________

Does the student require life sustaining equipment? □ Yes □ No If yes, see attached protocol ____________________________

Special diet, food allergies ____________________________

Comments ____________________________
Students With Special Health Care Needs

EMERGENCY PLAN

<table>
<thead>
<tr>
<th>Students Name</th>
<th>Date</th>
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<tr>
<td>Physician</td>
<td>Phone #</td>
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IF AN EMERGENCY OCCURS AND IS LIFE-THREATENING, IMMEDIATELY CALL 9-1-1 (Use the bus radio to contact the transportation office, so they can activate 9-1-1)

STUDENT SPECIFIC EMERGENCIES

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Emergency Care Plan

DIABETES - HYPOGLYCEMIA

Student:  
Grade:  
School Campus:  
DOB:  

Mother:  
MPhone #:  
MTel #:  
MCell #:  

Father:  
FHome #:  
FWork #:  
FCell #:  

Emergency Contact:  
Relationship:  
Phone:  

SYMPTOMS OF A HYPOGLYCEMIC EPISODE MAY INCLUDE ANY/ALL OF THESE:

- Shaking, fast heartbeat, sweating, anxiety, irritability
- Complaints of hunger, impaired vision, confusion, or fatigue
- Onset may be sudden and can progress to Insulin Shock

SEVERE SYMPTOMS INCLUDE:

- Appears very pale, feels faint, loss of consciousness
- Seizure activity

STAFF MEMBERS INSTRUCTED:

☐ Classroom Teacher(s)  
☐ Special Area Teacher(s)

d ○ Administration  
☐ Support Staff  
☐ Transportation Staff

TREATMENT:

Stop any activity immediately.

- Administer the student to the school nurse. Notify school nurse immediately.
- If off school grounds, provide a source of glucose:
  - 1/2 - 1 cup juice
  - Glucose tabs
  - Hard candy
  - Regular soda (not diet)
  - Glucose gel
  - Notify parents/guardian (do not delay treatment by calling - treat or obtain treatment for student first).

STEPS TO FOLLOW FOR A HYPOGLYCEMIC EMERGENCY:

Glucose ordered:  
☐ Yes  
☐ No

If Glucose is ordered, it should be given by a willing volunteer who has been trained by the school nurse if student is unconscious, unresponsive or having a seizure.

After Glucose is given, call 911. Notify parents. Prefered Hospital if transported.

Students receiving glucose without their parent or guardian present should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students in parent.

Healthcare Provider:  
Phone:  

Written by:  
Date:  

☐ Copy provided to Parent  
☐ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff:  

This plan is in effect for the current school year and summer school as needed.  

Revised: 1/08
Emergency Care Plan

SEIZURE DISORDER

Student: ___________________ Grade: _______ School Contact: _______ DOB: _______

Mother: ___________________ Mother Name: _______ MTel #: _______ MCell #: _______

Father: ___________________ Father Name: _______ FTelephone #: _______ FWork #: _______ FCell #: _______

Emergency Contact: _______ Relationship: _______ Phone: _______

SYMPTOMS OF A SEIZURE EPISODE MAY INCLUDE ANY/ALL OF THESE:

- Tonic-Clonic Seizure:
  - Entire body stiffness, jerking movements
  - May cry or moan loudly, be tired afterwards

- Absence Seizure:
  - Staring spell, may blink eyes

STAFF MEMBERS INSTRUCTED:

- Classroom Teacher(s)
- Support Staff
- Special Area Teacher(s)
- Transportation Staff

TREATMENT:

Clear the area around the student to avoid injury.

DO NOT PUT ANYTHING IN THE STUDENT’S MOUTH

Place student on side if possible, speak to student in reassuring tone
Stay with student until help arrives

- Emergency Medical Services (911) should be called, student transported to hospital
  - Preferred Hospital if transported

- Emergency medication to be given by Nurse at onset of seizure
- Student should be allowed to rest following seizure, call parent

Transportation Plan: [ ] Medication available on bus [ ] Medication NOT available on bus [ ] Does not ride bus
Special instruction: ______________________

Healthcare Provider: ___________________ Phone: __________________
Written by: ___________________ Date: __________________

[ ] Copy provided to Parent [ ] Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: ______________________

This plan is in effect for the current school year and summer school as needed.  Revised 1/08
Emergency Care Plan

BEE STING ALLERGY

Student: ___________________________________________ Grade: _______ School Contact: ___________ D.O.B. ___________

Asthmatic: □ Yes □ No (increased risk for severe reaction) Severity of reaction: ____________________________

Mother: ___________________ MPHome #: _______ MTel #: _______ MCell #: _______

Father: ___________________ FHome #: _______ Ftel #: _______ FCel #: _______

Emergency Contact: ___________________ Relationship: ___________ Phone: ______________________

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

• MOUTH: Itching & swelling of lips, tongue, or mouth
• THROAT: Itching, tightness in throat, hoarseness, cough
• EYES: Itchy, red, watery, swelling of face and ears
• STOMACH: Nausea, abdominal cramps, vomiting, diarrhea
• LUNG: Shortness of breath, repetitive cough, wheezing
• HEART: "Fluttery" feeling, "passing out"

The severity of symptoms can change quickly – it is important that treatment is given immediately.

STAFF MEMBERS INSTRUCTED: □ Classroom Teacher(s) □ Special Area Teacher(s)
□ Administration □ Support Staff □ Transportation Staff

TREATMENT:

Remove stinger if visible, apply ice to area.
Raise affected arm with ice.

Injection should be administered □ with symptoms □ without waiting for symptoms
Benadryl ordered: □ Yes □ No
Give ________ Benadryl per provider's orders

Call school nurse. Call parent/guardian if off school grounds.

Epinephrine ordered: □ Yes □ No
Special instructions: ____________________________

If any symptoms beyond redness or swelling at the site of the sting are present and epinephrine is ordered, give epinephrine immediately and call 911.

Prepared Hospital if transported:
Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian, or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: □ Medication available on bus □ Medication NOT available on bus □ Does not ride bus

Special instructions: ____________________________

Healthcare Provider: ___________________ Phone: ___________________

Written by: ___________________ Date: ___________

□ Copy provided to Parent □ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: ____________________________

This plan is to be used for the current school year and summer school as needed. Revised 1/08
Emergency Care Plan

FOOD ALLERGY

Student: ____________________  Grade: _______  School Contact: ______________  DOB: ________

Allergic: ☐ Yes  ☐ No (increased risk for severe reaction)  Allergen(s): ______________________

Mother: ____________________  MHome #: ______  MWork #: ______  MCell #: ______

Father: ____________________  FHome #: ______  FWork #: ______  FCell #: ______

Emergency Contact: ______________  Relationship: ______________  Phone: ______________________

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

☐ MOUTH: Itching & swelling of lips, tongue or mouth; “feels hot”

☐ THROAT: Itching, tightness in throat, hoarseness, cough

☐ SKIN: Hives, itchy rash, swelling of face and extremities

☐ STOMACH: Nausea, abdominal cramps, vomiting, diarrhea

☐ LUNG: Shortness of breath, repetitious cough, wheezing

☐ HEART: “Thready pulse”, “passing out”

The severity of symptoms can change quickly – it is important that treatment is given immediately.

STAFF MEMBERS INSTRUCTED: ☐ Classroom Teacher(s)  ☐ Special Area Teacher(s)  ☐ Support Staff  ☐ Transportation Staff

TREATMENT: Rinse contact area with water if appropriate.

Treatment should be initiated: ☐ with symptoms  ☐ without waiting for symptoms

Benadryl ordered: ☐ Yes  ☐ No  

Give _________ Benadryl per provider’s orders

Call school nurse. Call parent/guardian if off school grounds.

Epinephrine ordered: ☐ Yes  ☐ No  

Special instructions:

IF INGESTION OR SUSPECTED INGESTION OF ALLERGEN OCCURS, SYMPTOMS ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911

Packed Hospital if appropriate:

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: ☐ Medication available on bus  ☐ Medication NOT available on bus  ☐ Does not ride bus

Special instructions:

Healthcare Provider: ____________________  Phone: ____________________  Date: _____

Written by: ____________________  ☐ Copy provided to Parent  ☐ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Providers and School Staff

This plan is in effect for the current school year and summer school as needed.  Revised 1/08
Emergency Care Plan

FOOD ALLERGY

Student: ____________________  Grade: ________  School Contact: __________  DOB: __________

Allergic:  □ Yes  □ No (increased risk for severe reaction)  Allergen(s): ____________________________

Mother: ____________________  PHome #: ________  MWork #: ________  MCell #: ________

Father: ____________________  PHome #: ________  PWork #: ________  PCell #: ________

Emergency Contact: ____________________  Relationship: ________  Phone: ________

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- MOUTH: Itching & swelling of lips, tongue or mouth; mouth "feels hot"
- THROAT: Itching, tightening in throat, hoarseness, cough
- SKIN: Hives, rash, swelling of face and extremities
- STOMACH: Nausea, abdominal cramps, vomiting, diarrhea
- LUNG: Shortness of breath, repeated cough, wheezing
- HEART: "Tingly pubis", "passing out"

The severity of symptoms can change quickly -- it is important that treatment is given immediately.

STAFF MEMBERS INSTRUCTED:  □ Classroom Teacher(s)  □ Special Area Teacher(s)

TREATMENT:

- Rinse mouth with water if appropriate
- Treatment should be initiated □ with symptoms □ without waiting for symptoms
- Benzyl alcohol ordered:  □ Yes  □ No  Give _________ Benzyl alcohol provider's orders
- Call school nurse. Call parent/guardian if off school grounds.
- Epinephrine ordered:  □ Yes  □ No  Special instructions: __________________________

IF INGESTION OR SUSPECTED INGESTION OF ALLEGEN OCCURS, SYMPTOMS ARE PRESENT
AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

First Aid: If allergic reaction is present:

- Adopt patented technique, providing 6 doses of 0.3 mL

IF INJECTION IS NOT ADMINISTERED IN 6 MINUTE TIME FRAME:
- Call school nurse, call emergency contact
- Stay with student until emergency contact arrives

Call school nurse. Call emergency contact if off school grounds.

Transportation Plan:  □ Medication available on bus  □ Medication NOT available on bus  □ Does not ride bus

Special instructions: __________________________

Healthcare Provider: ____________________  Phone: ____________________

Written by: ____________________  Date: ________

□ Copy provided to Parent  □ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Providers and School Staff: __________________________

This plan is in effect for the current school year and summer school as needed.  Revised 1/06
Emergency Care Plan

LATEX ALLERGY

Student: __________________ Grade: ______ School Contact: _______ DOB: _______
Mother: __________________ MHome #: ______ MWork #: _______ MCell #: _______
Father: __________________ FHome #: ______ FWork #: _______ FCell #: _______
Emergency Contact: _______ Relationship: _______ Phone: _______

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- MOUTH: Itching or swelling of lips, tongue or mouth
- THROAT: Itching, tightness in throat, hoarseness or throat
- SKIN: Hives, rash, hives rash, generalized swelling
- STOMACH: Nausea, abdominal cramps, vomiting and/or diarrhea
- LUNG: Shortness of breath, repetitive cough, wheezing
- HEART: "Thready pulse", "passing out"

The severity of symptoms can change quickly—
it is important that treatment is given immediately.

STAFF MEMBERS INSTRUCTED: ☐ Classroom Teacher(s) ☐ Special Area Teacher(s)
☐ Administration ☐ Support Staff ☐ Transportation Staff

TREATMENT:

Rinse contact area with water.

Benadryl ordered: ☐ Yes ☐ No Give ______ Benadryl per provider's order.

Call school nurse at _________, Call parent/guardian if off school grounds.

Epinephrine ordered: ☐ Yes ☐ No Special instructions: _______

IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING ARE SEEN AT THE SITE AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Preferred Hospital if transported:

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: ☐ Medication available on bus ☐ Medication NOT available on bus ☐ Does not ride bus

Special instructions: _______

Healthcare Provider: ___________________ Phone: ___________________

Written by: ___________________ Date: ____________

☐ Copy provided to Parent ☐ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff:

This plan is in effect for the current school year and summer school as needed.

Revised 1/08
Emergency Care Plan

ASTHMA

Student: ___________________ Grade: ___________ School Contact: ___________________ DOE: ___________

Asthma Trigger(s): ___________________ Best Peak Flow: ___________________

Mother: ___________________ Home #: ___________ Work #: ___________ Cell #: ___________

Father: ___________________ FHome #: ___________ FWork #: ___________ FCell #: ___________

Emergency Contact: ___________________ Relationship: ___________ Phone: ___________

Symptoms of an Asthma Episode may include any/all of these:

- Changes in breathing: coughing, wheezing, breathing through mouth, shortness of breath, peak flow of <_________.
- Appears: anxious, teary-eyed, restless, tired, flushed with chills, hunched over, and cannot straighten up easily.

Signs of an Asthma Emergency:

- Breathing with chest and/or neck pulled in, sits hunched over, nose open wide when talking. Difficulty in walking and talking.
- A rise in respiratory rate and/or tachypnea.
- Failure of medication to reduce worsening symptoms with no improvement 15 - 20 minutes after initial treatment.
- Peak Flow of ________ or below.
- Respirations greater than 30/minute.
- Pulse greater than 120/minute.

Staff Members Instructed:

- Classrooms Teacher(s)
- Special Area Teacher(s)
- Administration
- Support Staff
- Transportation Staff

Treatment:

Step I: Activity Immediately.
- Help student assume a comfortable position. Sitting up is usually more comfortable.
- Encourage pursed-lipped breathing.
- Non-rule fluids to decrease thickness of lung secretions.
- Give medications as ordered.

Step II: Observe for relief of symptoms. If no relief noted in 15 - 20 minutes, follow steps below for an asthma emergency.

Notify school nurse at ___________, who will call parents/guardian and healthcare provider.

Steps to Follow for an Asthma Emergency:

- Call 911 (Emergency Medical Services) and inform that you have an asthma emergency. They will ask the student's age, physical symptoms, and what medications he/she has taken and usually taken.
- A staff member should accompany the student to the emergency room if the parent, guardian, or emergency contact is not present and adequate supervision for other students is present. Preferred Hospital if transported: ___________.

Healthcare Provider: ___________________ Phone: ___________

Written by: ___________________ Date: ___________

☐ Copy provided to Parent ☐ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: ___________________

This plan is in effect for the current school year and summer school as needed. Revised 1/07

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Emergency Care Plan

ASTHMA

Student: ___________________ Grade: _____ School Contact: ___________ DOB: ___________

Asthma Triggers: ____________________ Best Peak Flow: ___________

Mother: ______________________ MHome #: __________ MWork #: __________ MCell #: __________

Father: ______________________ FHome #: __________ FWork #: __________ FCell #: __________

Emergency Contact: __________________ Relationship: __________ Phone: __________

SYMPTOMS OF AN ASTHMA EPISODE MAY INCLUDE ANY/ALL OF THESE:

• CHANGES IN BREATHING: coughing, wheezing, breathing through mouth, shortness of breath, peak flow of <__________.

• VERBAL REPORTS of chest tightness, chest pain, cannot catch breath, dry mouth, "itchy throat" (wheeze), chest "cramps" (sneezes, feels tight when breathes loudly).

• APPEARS: anxious, treated, restless, frigid,手中 with clenched fists, hand over nose and cannot straighten up easily.

SIGNS OF AN ASTHMA EMERGENCY:

• Breathing with chest and/or neck pulled in, or chest braced over, nose open wide when talking. Difficulty in walking and talking.

• Cyanosis, cyanosis of lips and/or fingertips.

• Failure of medication to reduce worsening symptoms with no improvement 15 – 20 minutes after initial treatment.

• Peak Flow of <__________ or below.

• Respirations greater than 30/min.

• Pulse greater than 120/minute.

STAFF MEMBERS INSTRUCTED: ❑ Classroom Teacher(s) ❑ Special Area Teacher(s)
❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT:

Step activity immediately.

Help student assume a comfortable position. Sitting up is usually more comfortable.

Encourage pursed-lipped breathing.

Instruct student to increase distance between hands and feet.

Give medications as ordered.

Observe for relief of symptoms. If no relief noted in 15 – 20 minutes, follow steps below for an asthma emergency.

Notify school nurse at ____________, who will call parents/guardians and healthcare provider.

STEPS TO FOLLOW FOR AN ASTHMA EMERGENCY:

• Call 911 (Emergency Medical Services) and inform that you have an asthma emergency. They will ask the student’s age, physical symptoms, and what medications he/she has taken and usually take.

• A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present. Preferred Hospital if transported ____________________.

Healthcare Provider: __________________ Phone: __________

Written by: __________________ Date: __________

❑ Copy provided to Parent ❑ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: ____________

This plan is in effect for the current school year and summer school as needed. Revised 1/08

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DIABETES - HYPERGLYCEMIA

Student: ___________________________ Grade: ___________ School Contact: ___________ DOB: ___________

Mother: ___________________________ MPhone #: ___________ MWork #: ___________ MCell #: ___________

Father: ___________________________ FPhone #: ___________ FWork #: ___________ FCell #: ___________

Emergency Contact: ___________________________ Relationship: ___________ Phone: ___________

SYMPTOMS OF A HYPERGLYCEMIC EPISODE MAY INCLUDE ANY/ALL OF THESE:

- Gradual onset
- Extreme thirst, very frequent urination, decreased
- Weakness, dry skin, heavy breathing, blurred vision
- Vomiting, fruity or wine-like odor to breath

SEVERE SYMPTOMS INCLUDE:

- Stupor
- Unconsciousness

STAFF MEMBERS INSTRUCTED:

☐ Classroom Teacher(s) ☐ Special Area Teacher(s)

☐ Administration ☐ Support Staff ☐ Transportation Staff

TREATMENT:

Stay with the student.
Notify school nurse immediately.
Call 911 to access Emergency Medical Services — transport to hospital by ambulance.
Preferred Hospital if transported: ___________

Notify parents/guardian (do not delay treatment by calling — obtain treatment for student first).

Healthcare Provider: ___________________________ Phone: ___________________________

Written by: ___________________________ Date: ___________

☐ Copy provided to Parent ☐ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Providers and School Staff: ___________________________

This plan is in effect for the current school year and summer school as needed. Revised: 1/08