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 IHCP.

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.

Sources:

National Association of School Nurses. (2015). *Individualized health care plans: The role of the school nurse* (Position Statement). Silver Spring, MD: Author.

Schwab, N. (2005). *Legal issues in school health services: A resource for school administrators, school attorneys, school nurses*. Authors Choice Press.

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: _____

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

Medical Care

Primary Health care Provider_____Phone _____

Specialty Health care Provider_____Phone _____

Health History

Brief Health History

_____

_____

_____

_____

_____

_____

Special Health care Needs _____

_____

_____

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

Medication & Dietary Needs

Current Medications (dose, route, time)

_____

_____

_____

Special Dietary Requirements

_____

_____

_____

Allergies (include type of reaction)

_____

_____

_____

Individualized Health Care Plan - Components

Assessment Data	Nursing Diagnosis	Goals	Nursing Interventions	Expected Outcomes

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 _____

Date/Time	Procedure notes	Observations	Time for Prep, Proc, Doc	Completed by

Emergency Care Plan (or Emergency Action Plan)

Student Name_____ Class/Grade _____

Parent/Guardian_____ Phone _____

Parent/Guardian_____ Phone _____

Health care Provider_____ Phone _____

If you see this	Do this

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.

_____

_____

_____

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** _____

For office use only:
LSN Signature_____Date _____

Name of Staff Routing_____Date _____

Please check off who was routed this form ___Student File _IEP Manager _Building Nurse __Other

Consent for Administration of Special Health Care Procedures

Print Form

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

Students Name _____ Date _____

Physician _____ Phone # _____

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

IF YOU SEE THIS	DO THIS

Emergency Care Plan

Sample

DIABETES - HYPOGLYCEMIA

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Mother: _____ MHome #: _____ MWork #: _____ 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, weakness or fatigue
- **Onset may be sudden and can progress to Insulin Shock**

Student Photo

SEVERE SYMPTOMS INCLUDE:

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

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

TREATMENT:

Stop any activity immediately.
Accompany the student to the Health Office. Notify school nurse immediately.
If off school grounds, provide a source of glucose:
- ½ - ¾ 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:

Glucagon ordered: ❑ Yes ❑ No
If Glucagon 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 Glucagon is given, call 911. Notify parents Preferred Hospital if transported: _____
Students receiving glucagon 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 is present.

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

Sample

SEIZURE DISORDER

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

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

- ❑ Tonic-Clonic Seizure:
  - Entire body stiffens, jerking movements
  - May cry out, turn blnish, be tired afterwards
- ❑ Absence Siezure:
  - Staring spell, may blink eyes

Student Photo

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

Sample

Emergency Care Plan

BEE STING ALLERGY

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Asthmatic: ❑ Yes ❑ No (increased risk for severe reaction) Severity of reaction(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
- **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, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

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

Student Photo

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

TREATMENT: Remove stinger if visible, apply ice to area. Rinse contact area with water.

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 ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING ARE PRESENT 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

Sample

FOOD ALLERGY

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Asthmatic: ❑ 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, 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, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

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

Student Photo

STAFF MEMBERS INSTRUCTED: ❑ Classroom Teacher(s) ❑ Special Area Teacher(s) ❑ Administration ❑ 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.

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

Sample

FOOD ALLERGY

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Asthmatic: ❑ 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, 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, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

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

Student Photo

STAFF MEMBERS INSTRUCTED: ❑ Classroom Teacher(s) ❑ Special Area Teacher(s) ❑ Administration ❑ 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.

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

Sample

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 & swelling of lips, tongue or mouth
- **THROAT** Itching, tightness in throat, tightness in chest
- **SKIN** Hives, warmth, itchy 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 give immediately.

Student Photo

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 orders

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

Sample

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, "neck feels funny", doesn't feel well, speaks quietly.
- **APPEARS:** anxious, sweating, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily.

Student Photo

SIGNS OF AN ASTHMA EMERGENCY:

- Breathing with chest and/or neck pulled in, sits hunched over, nose opens wide when inhaling. Difficulty in walking and talking.
- Blue-gray discoloration of lips and/or fingernails.
- 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: ❑ Classroom Teacher(s) ❑ Special Area Teacher(s) ❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT:

Stop activity immediately.
Help student assume a comfortable position. Sitting up is usually more comfortable.
Encourage purse-lipped breathing.
Encourage fluids to decrease thickness of lung secretions.
Give medication 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/guardian and healthcare provider.

STEPS TO FOLLOW FOR AN ASTHMA EMERGENCY:

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

Emergency Care Plan

Sample

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, "neck feels funny", doesn't feel well, speaks quietly.
- **APPEARS:** anxious, sweating, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily.

Student Photo

SIGNS OF AN ASTHMA EMERGENCY:

- Breathing with chest and/or neck pulled in, sits hunched over, nose opens wide when inhaling. Difficulty in walking and talking.
- Blue-gray discoloration of lips and/or fingernails.
- 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: ❑ Classroom Teacher(s) ❑ Special Area Teacher(s) ❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT:

Stop activity immediately.
Help student assume a comfortable position. Sitting up is usually more comfortable.
Encourage purse-lipped breathing.
Encourage fluids to decrease thickness of lung secretions.
Give medication 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/guardian and healthcare provider.

STEPS TO FOLLOW FOR AN ASTHMA EMERGENCY:

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

Sample

Emergency Care Plan

DIABETES - HYPERGLYCEMIA

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

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

- Gradual Onset
- Extreme thirst, very frequent urination, drowsiness
- Flushed skin, heavy breathing, blurred vision
- Vomiting, fruity or wine-like odor to breath

Student Photo

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 Provider and School Staff: _____

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