| **Emergency action plan**Utah Department of Health and Human ServicesUtah State Board of Education | School year: | Picture |
| --- | --- | --- |
| Student name: |  | Date of birth: | Grade: |
| School: | Homeroom: | School Phone: | School Fax: |
| **Demographic information (Parent/Guardian)** |
| Student’s cell phone # |  |  |
| Parent #1 name: | Phone: | Email: |
| Parent #2 name: | Phone: | Email: |
| **Brief medical history** |
| Medical diagnosis: |
| A brief description of the condition or concern: |
| Baseline status: |
| **Emergency action plan** |
| **If you see this:** Signs and symptoms to watch for | **Do this:** Immediate actions to take |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Emergency protocol** | **Expected behavior after event** | **Follow up** |
| * Call 911
* Transport to:
* Call parent or emergency contact
* Administer emergency medications
* Other (specify):
 | * Tiredness
* Weakness
* Sleeping, difficult to arouse
* Regular breathing
* Other (specify):
 | * Document
* Call school nurse
* Other (specify):
 |
| **Special considerations** |
| Does the student have special healthcare needs that school staff should be aware of?*(Examples: tube feedings, oxygen use, respiratory support, seizure precautions, etc.)** No
* Yes — please describe:
 |
| 2. Are there any special considerations or precautions needed during the school day?* No
* Yes — please describe:
 |
| 3. Does the student require special care during transportation?* No
* Yes — please describe:
 |

| **Medications:**  |
| --- |
| **Note: This form alone is not a valid medication authorization**If medication is ordered, a separate Medication Authorization Form must be completed, signed by the healthcare provider, and returned to the school. |
| **Emergency or rescue medications**  |
| Medication | Dose  | Route | Time | Side effects |
|  |  |  |  |  |
|  |  |  |  |  |
| Person to give rescue medication: ☐School nurse ☐ Parent ☐EMS ☐ Volunteer(s) (Specify:)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Location of rescue medication: |
| **Routine medications (see above statement)** |
| Person to give routine medication at school: ☐ School nurse ☐ School staff (Specify): |
| Medication | Taken at home or school? | Dose | Route | Time | Side effects |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Location of routine medication: |
| Equipment Instructions: if applicable |
|  |
|  |
| School nurse contact: |  | Phone | Email: |
| Parent name: |  | Phone: | Email: |
| Parent name: | Phone: | Email: |
| Name of healthcare provider: |  | Phone: |  |
| Clinic name: |  | Fax: |