| **Emergency action plan**  Utah Department of Health and Human Services  Utah 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 | | | | |
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| **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 | |
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|  |  |  | | |  |  |  | |
| 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: | | |