



EMERGENCY ACTION/ HEALTH CARE PLAN & AUTHORIZATION FOR MEDICATION ADMINISTRATION

Student's
Photo

TO BE COMPLETED BY PARENT:

Student Name _____ DOB _____ School _____ Grade _____

Parent/Guardian _____ Phone (H) _____ Phone (W) _____ Phone(Cell) _____

Address _____ City _____ Zip _____

Emergency contact _____ Relationship _____ Phone _____

Emergency contact _____ Relationship _____ Phone _____

Name of physician _____ Office phone number _____

TO BE COMPLETED BY THE PHYSICIAN:

DIAGNOSIS _____

POSSIBLE SYMPTOMS: _____

EMERGENCY ACTION IS NECESSARY IF THE STUDENT HAS THE FOLLOWING SYMPTOMS!!!

A. Steps to take as emergency support:

1. _____
2. _____
3. _____
4. _____

B. May return to classroom if _____

C. Contact parent/guardian if _____

DAILY MANAGEMENT PLAN:

1. Identify areas which may aggravate the disorder (exercise, foods, etc):

2. Special Procedures _____

_____ Educational concerns _____

_____ Physical Education concerns _____

_____ Sports Precautions concerns _____

_____ Recess Precautions _____

_____ Special Considerations on Field Trips _____

_____ Other _____

Physician and Parent Signature Required. Please turn to the other side to complete and sign. Thank You! →→



Dear Parent or Guardian:

The Lynchburg City Schools attempts to discourage administration of medication during school hours, and request whenever possible medication doses be scheduled other than school hours. Recognizing that this is not always possible, we will cooperate in giving medication that must be given during school time. Our regulations include:

1. Written orders using this form from a physician, detailing the name of the medication, dosage, route, and time interval of medication to be taken and plan of care.
2. Using this form, the signature of the parent or guardian requesting that the school district comply with the physician's order and plan of care
3. Medication must be brought to school by the parent or guardian in a container appropriately labeled by the pharmacy.

MEDICATION(S)

Name	Dose	Route	Time
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I have prescribed the medication(s) listed above and reviewed the plan of care for this student. The plan is in accordance with the student's medical management. Current School Year (please check)

Physicians signature

Date

PARENTAL CONSENT

I give my permission for school personnel to follow the plan and use the designated medications in accordance with the above instructions. I understand that I am responsible for providing the school with the prescribed medication needed by my child. I acknowledge that I have read, understand, and do now support the Health Care Plan as outlined above. I agree to allow information on this Health Care Plan to be shared with the adults responsible for my child's care. I hereby release the Lynchburg City School Board, its employee and agents from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance. I am aware that should I move to another attendant zone with Lynchburg City, I will need to work with the new school to continue with the above health care plan for my child.

Signature of Parent/Guardian

Date

Signature of Nurse/Health Assistant

Date

A new Health Care Plan is required on an annual basis and a revision with any significant change in the student's health status
Lynchburg City Schools Emergency Health Care Plan



EMERGENCY ACTION/ HEALTH CARE PLAN COVER SHEET

Please check which of the following documents is attached as a part of the Individual Health Care Plan:

- An emergency care/response plan
- A statement of the agreed responsibilities of different people involved in the student's support
- A schedule for the administration of prescribed medication
- A schedule for the administration of health care procedures
- An authorization to contact the medical practitioner
- Other documents—please specify-----

The individual health care plan has been developed as part of the learning support plan in consultation with those indicated and with the knowledge and agreement of the student's parent/ guardian/caregiver

Information has been provided by:

Student/Parent/Caregiver/General Practitioner/ Medical Specialist (please circle all that apply)

School staff involved in plan development:

- 1.----- Position -----
- 2.----- Position -----
- 3.----- Position -----

Health Care personnel involved in managing the student's health at school: (i.e. Community Nurse, Therapist)

- 1.----- Phone: -----
- 2.----- Phone: -----