Santa Rosa County Public Schools
Individual Emergency Health Care Plan
School_____

grade__Teacher_____Year_____
grade__Teacher_____Year_____
grade__Teacher_____Year_____

Student Name:_____DOB_____
Parent:_____Phone#1_____Phone#2_____
2nd Parent:_____Phone#1_____Phone#2_____
Emergency Contact:_____Phone:_____
2nd Emergency Contact:_____Phone:_____
Physician Name:_____Phone:_____
Specialist Name:_____ Phone:_____

1. Health condition/ Length of time condition has existed: **Allergy**
Reaction occurs if student has following type of contact: ☐ Ingestion ☐ Skin contact ☐ Inhalation ☐ Other:_____

2. Allergies:

- ☐ **Food** _____
- ☐ **Medication**_____
- ☐ **Other** _____

3. Medications at home	**Medications at school**	**Medication Storage Location**
_____	_____	☐ Classroom
_____	_____	☐ Clinic
_____	_____	☐ Student Backpack
_____	_____	☐ Other:_____
_____	_____	_____

4. Potential Emergency Situation

- Swelling of the lips, tongue, or eyes
- Swelling or tightness in throat
- Difficulty talking/hoarse voice
- Difficulty breathing or noisy breathing
- Wheezing or persistent cough
- Vomiting, stomach cramps, diarrhea
- Rash, Hives or Welts
- Loss of Consciousness and/or collapse
- Blue Discoloration of lips or fingernails
- Student becomes pale or floppy
- Other:_____-

Emergency Response

- Stay calm
- Stay with student and escort student to the clinic
- Give medications as ordered by doctor/parent
  Give **Benadryl** immediately for mild reactions
  Administer as directed

  Give **Epinephrine Autoinjector** immediately for severe reactions such as difficulty breathing,
  _____ _____etc.
  Route: IM Amount: 1 Pen
- Other_____

Call 9-1-1 immediately if: Epipen/Twinjet given lips or fingernails turn blue or gray, breathing worsens, continuous spasmodic coughing, continued swelling of lips, throat, or tongue, loss of consciousness/collapse, start **CPR immediately if student stops breathing and has no pulse.**

5. Special Needs/Limitations
Diet:_____
_____
Student needs to sit at nut free table in lunchroom yes ☐ no☐ _____
Activity Level/Physical Restrictions: _____
_____
_____
Classroom considerations:_____
_____
_____

6. Other Considerations: Take emergency medication/s ( ) on all off campus activities
_____

Send Copies To: __Teacher __Clinic __Guidance __PE __Art __Music __Cafeteria __Teacher Asst. __Bus Driver
__School Nurse __Media Center Specialist __Athletic Director __Other_____

Student Name_____

By my signature on this form, I acknowledge receipt of the Notice of the Privacy Practices Act, and authorize designated Santa Rosa County School District personnel, Santa Rosa County Health Department School Health personnel, and any other contracted healthcare agencies to provide emergency care for my child and/or to exchange medical information as necessary to support the continuity of care of my child.

Parent Signature_____**Date**_____

☐ **Obtained via telephone interview with parent** **School Year** _____

Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**School Health Technician**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

*: Update to Individual Emergency Health Care Plan **School Year** _____

Status determined by:

☐ **person-to-person interview**
☐ **telephone interview**
☐ **Update letter**

_____ No changes to current plan

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

*: Update to Individual Emergency Health Care Plan **School Year** _____

Status determined by:

☐ **person-to-person interview**
☐ **telephone interview**
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Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Note: 1.** ***significant changes to the plan of care require a new Emergency Health Care Plan be completed.
2. At the beginning of the 4th update or revision a new plan will be written.

Revised: Sept. 2013