HARRISBURG SCHOOL DISTRICT 41-2

GENERIC ACTION PLAN

Student's Name: _____ Birth Date: ____/____/____ M ☐ F ☐

School: _____ Grade:_____ Teacher:_____ Rides Bus: Yes ☐ No ☐

Mother's Name: _____ Phone: H)_____ C)_____ W)_____

Email: _____ Employer/Occupation: _____

Father's Name: _____ Phone: H)_____ C)_____ W)_____

Email: _____ Employer/Occupation: _____

Child lives with: _____ Hospital Preference: _____

Physician's Name: _____ Phone: _____

Emergency Contact: _____ Phone:_____

My child's Medical Condition/Concern:
_____
_____
_____

Does the medical condition/concern require school restrictions, modifications and/or intervention?
(additional paperwork may need to be completed/required)
☐ YES ☐ NO If YES, please explain:_____

Does student require any special procedures and/or treatments for their health condition/concern?
(additional paperwork may need to be completed/required)
☐ YES ☐ NO If YES, please explain:_____

Has student been hospitalized for medical condition/concern?
☐ YES ☐ NO If YES, please explain:_____

Are medications required to control the medical condition/concern: ☐ YES ☐ NO
(additional paperwork may need to be completed)

Please list prescription and over-the-counter medications that you child will need during school day.

MEDICATION	TIME	REASON

Children K-5 are not allowed to carry and self-administer any medications, including cough drops. Exceptions made for Asthma and Anaphylactic medications. Medications maybe administered from the health office with proper Medication Administration Form. Forms must be completed by parent/guardian, medications delivered to the health office by parents, and in the original container.

***In Harrisburg, EMS will be activated by a call to 911 at which time we will state that we need transport to the hospital by Rural Metro. Harrisburg Volunteer Fire Department is typically first on the scene to further assist.**

*A **Medication and Treatment Authorization Form** must be completed and kept on file in the school health office. New Health Care Plans are completed yearly. Any updates throughout the school year should be submitted to the School Nurse.

* *This information will be come part of your child's confidential permanent record. If for any reason you do not wish to respond to part(s) of this form you are under no obligation to do so. Please understand that we are not responsible for injury or illness that may be a result of these omissions.*

Physician Signature _____ **Date** _____

By signing below I understand that I am giving my permission to share this information with school staff/trained personnel as needed with strict confidentiality maintained by all. I also give my permission for the school nurse/aide to contact the Primary Care Physician or Allergist if further information or clarification is needed.

Parent/Guardian Signature:_____ Date:_____

OFFICE USE ONLY

Reviewing Nurse Signature: _____ Date:_____

☐ Physician Documentation ☐ Special Diet Request Form

☐ Medication and Treatment Authorization Form ☐ Other_____

Staff Notified: ☐ Teacher ☐ Bus Driver ☐ Nutritional Service

☐ SPED ☐ Principal ☐ Nursing Supervisor