OUR SHEPHERD LUTHERAN SCHOOL

508 Mentor Ave. Painesville Oh. 44077
Phone: 440-357-7776 Fax: 440-358-1149

GENERAL EMERGENCY ACTION PLAN

Student's Name______________________________________ **Date of Birth**_____________ **Grade**________

Parent/Guardian #1 Name______________________________**Phone# M**_____________**W**______________

Parent/Guardian #2 Name______________________________**Phone# M**_____________**W**______________

Bus Rider? ❒ **No** ❒ **Yes** **Bus #** _________

List of medical problems your student has:
____
____
____

Doctor seen/Phone #/Date last seen:
____
____
____

Specific action(s) to be taken in the care of your child:____
____

Allergies ❒ **No known allergies** ❒ **Yes** **If yes, list allergens, signs/symptoms and treatment below:**
____
____

Medications ❒ None	Dosage	When to use	Reason for use	Prescriber name and number

Information regarding dates of diagnoses/surgeries/treatments/significant changes:_______________
____
____

Has your child ever been in the hospital? ❒ **No** ❒ **Yes** **If yes, list when, reason and outcome:**
1.____
2.____

Review of Body Systems-give details regarding any of the following issues:

Vision: ❒ **NA**________________________________**Gastrointestinal:** ❒ **NA**
____
Hearing: ❒ **NA**______________________________ **Communication:**❒ **NA**____________________________
Heart: ❒ **NA** ________________________________**Dental:** ❒
NA_____________________________________
Lungs: ❒ **NA** ________________________________**Nutrition/swallowing:** ❒ **NA**________________________
Bones/Muscles: ❒ **NA**________________________**Skin:** ❒ **NA**
____

Other:____
Other:____

Are there any accommodations needed at school? ❒ **No** ❒ **Yes If yes, list below:**_______________
____

Home care: ❒ **No** ❒ **Yes If yes, list name, location and phone # of agency, contact person and services provided:**____
____

Equipment used: ❒ **No** ❒ **Yes If yes, list type of equipment and name, location and phone # of the company providing equipment:**____
____

Public Programs involved/Services provided: ❒ **No** ❒ **Yes If yes, list name, location and phone # of agency, contact person and services provided:**____
____

Additional Comments/Instructions:____
____
____

Nurses Notes:____
____
____

Emergency Contact #1
Name:___________________________**Relationship:**_____________________**Phone #**__________________

Emergency Contact #2
Name:___________________________**Relationship:**_____________________**Phone #**__________________

Emergency Contact #3
Name:___________________________**Relationship:**_____________________**Phone #**__________________

➡ **Doctor's Name:**__________________________**Signature**___________________________ **Date** __________

Address___________________________________**Phone #**__________________**Fax #**___________________

➡ **Parent/Guardian Signature:**____ **Date:**________________

I hereby give permission for Our Shepherd Lutheran School to exchange specific confidential information with_____________________ (Physician/Clinic) on my child _____________________ to develop more effective ways of providing for the healthcare needs of my child in school.

Nurse Signature:____Date___________