New Albany-Floyd County Consolidated School Corporation
Health Services
2023-2024 School Year

Attach child's photo

General/Procedure Action Plan

Child's name: _____ School: _____
Grade _____ Teacher: _____ Date of birth: ____/____/_____ Age _____
Child's diangosis_____

_____

Procedure to be performed (if medication involved, please complete medication form):

_____

_____

- Time schedule/indication for procedure: _____
  _____
- Possible emergencies related to condition/procedure: _____
  _____
- How to respond to emergency: _____

  _____

Precautions at school: _____
_____

_____

Other comments/recommendations: _____
_____

Duration of need for procedure/precautions:
☐ Throughout school year ☐ Until _____

For emergency related to condition or procedure:	Monitor child What to do
If child has any sign/symptom noted above OR: • Severe difficulty breathing unresponsive to prescribed asthma medication orders • Dislocation/removal of g-tube and parent/emergency contact not reachable • Loss of or change in level of consciousness • Severe injury ***Please note: When any changes in student's typical characteristics are observed, the parent/guardian must be notified immediately.**	1. Call 911 and then the school nurse. 2. Notify school personnel trained in CPR/First Aid to stay with student and provide care if needed prior to EMS arrival. 3. Contact parent/guardian immediately. 4. When student is transported via EMS, NAFCS staff must accompany student unless parent and/or emergency contact accompanies them. 5. If student requires emergency medical treatment while on the bus, driver/transportation will contact EMS.

_____ _____ _____ _____
*Parent/Guardian Authorization Signature Date Physician/HCP Authorization Sign. Date

_____ _____
*Parent/Guardian Printed Name Physician/HCP Printed Name

Child's name: _____

Contacts

Call 911

Doctor/HCP: _____ Phone: (____) _____-_____

Parent/Guardian: _____ Phone: (____) _____-_____

Parent/Guardian: _____ Phone: (____) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (____) _____-_____

Name/Relationship: _____ Phone: (____) _____-_____

***Please note:**

By signing page 1, I give permission to the school nurse and other trained personnel members to perform the tasks as outlined in the General/Procedure Action Plan. I understand that a school nurse is not always present at my child's school and I give consent for other trained school personnel to provide care to my child as needed according to this plan. I give permission for the school nurse and prescribing health care provider to exchange information regarding any necessary procedure order clarifications, response to procedure, and adverse effects. I also consent to the release of information contained in this General/Procedure Action Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. Unless other arrangements are made, I give the school permission to send home medication/supplies that has been in its possession with my child at the end of the school year.

For School Personnel:

Please note:

- **If 911 called, NAFCS staff must accompany student on/with ambulance unless parent and/or emergency contact accompanies them.**
- **Document emergency event and any medications given. Give used device to EMS.**
- **Ensure assistive personnel notifies ASC of 911 call made.**
- **If prescribed medical treatment is not available to school personnel, call EMS for any severe or life threatening signs or symptoms. Contact school nurse.**
- **Please ensure emergency medication/supplies are taken on all field trips.**
- **Be sure to share this information with any substitute teacher.**

Personnel who are trained including the date of training:	**Location of supplies:**
1. _____ Date _____ **2. _____ Date _____** **3. _____ Date _____** **4. _____ Date _____** **5. _____ Date _____** **6. _____ Date _____** **7. _____ Date _____** **8. _____ Date _____** **9. _____ Date _____** **10. _____ Date _____**	☐ **Health office** ☐ **With student_____** ☐ **Classroom** ☐ **Specials classrooms** ☐ **Bus** ☐ **Other _____**

This plan has been reviewed and approved by:	**Copies of HCAP given to/Date given:**
_____ **School Nurse's Signature Date** _____ **Building Principal's Signature Date**	**Health Office _____ Teacher (Elem)_____** **Principal_____ OR (Sped) _____** **Cafeteria_____ IEP(Sped) _____** **ESC (Sped)_____ Bus/Aide_____** **Transportation (if med in backpack for use on bus)_____** **All trained staff_____**