

Whitehall-Coplay School District
Emergency Action Plan (EAP) -*Specified Condition*

Place
Child's
Photo
Here

Student: _____ Date: _____
Teacher/Classroom: _____ Bus: _____
Allergies: _____
Physician/Health Care Provider: _____
Hospital Preference: _____

TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER

Condition/Diagnosis: _____

Signs and symptoms:

Treatment plan for school and/or during an athletic event:

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

Medications:

Emergency Calls

1. Parent/Guardian: _____

2. Additional Contacts: _____

3. Physician: _____
Physician Signature: _____ Date: _____
Parent Signature: _____ Date: _____
School Nurse: _____ Date: _____

School personnel informed: copies are distributed on a need to know:
 Classroom teacher PE Art Library Music Cafeteria/Recess
 Guidance Office Personnel

Care Plans are updated yearly and/or throughout the school year needed.

WHITEHALL-COPLAY SCHOOL DISTRICT

Medication Dispensing Form

To the Physician:

Please complete and sign this form if you request your patient to receive a medication during school hours. By signing this form, you are indicating that the student could not attend school unless this medication was available during the school day.

Medication must be brought in the original bottle and will be kept in the health room. It will be the student's responsibility to request the medication in the health room.

Student's name: _____ Grade: _____ Teacher: _____

Prescribed medication: _____

Dosage*, route, and frequency: _____

Time of day to be given: _____

Reason for medication: _____

Side effects: _____

Is child taking any other medication? Name? _____

This authorization is in effect from: _____ to: _____ **

Student may carry INHALER / EPIPEN (circle choice) and use as prescribed by licensed provider.

*Licensed Prescriber signature: _____ Date: _____

Print name of Licensed Prescriber: _____

Telephone # of Licensed Prescriber: _____

I do hereby release, discharge, and hold harmless, the Whitehall-Coplay School District, its agents and employees, from any and all liability claim for the administration of the above medication to my child and for any and all injuries resulting there from. I consent for employees of Whitehall-Coplay School District to exchange information regarding this medication with the physician who ordered the medication. Please refer to the school calendar for policies related to medications.

Parent /Guardian signature: _____ Date: _____

**If the dosage is changed at any time, physician must complete new form. Please request additional forms as needed from the school nurse or obtain on-line at www.whitehallcoplay.org.*

***This form is only valid for school year in which it was completed.*

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