Place student picture here

SHUNT EMERGENCY ACTION PLAN/504

NAME:			**Birthdate:**		**Teacher:**	
Grade:		**School:**		☐ **Bus #**		☐ **Walk** ☐ **Drive**
Doctor:		**Phone:**		**Fax:**		**Preferred Hospital:**
Shunt Condition/Concern:						

Wears medical alert bracelet? YES □ NO □

Action:

- **If the student receives any blow to the head, neck, or abdomen, REPORT PROMPTLY TO NURSE AND PARENT.**
- **Monitor student through the remainder of the school day for symptoms listed below.**
- **Do not allow the student to ride the bus or walk home, etc. if blow to head has occurred in preceding hour or if the student is symptomatic.**

Potential symptoms/concerns:

Additional information from LHP:

LHP Signature	Date	Telephone: Fax Number:
LHP Printed Name	Start Date:	End Date:

(Spokane Public Schools Health Services revised 5/20)

PARENT/GUARDIAN SECTION

EMERGENCY CONTACTS

Name
Home Phone
Work Phone
Other

Name
Home Phone
Work Phone
Other

ADDITIONAL EMERGENCY CONTACTS:

1.	Relationship:	Phone:
2.	Relationship:	Phone:

****Does the student need classroom, school activity, or recess accommodations? ___yes ___no. If yes, please contact the school counselor.**

- A new health care plan for health conditions must be submitted each school year.
- I understand that if any changes are needed on the HCP, it is the parent's responsibility to contact the school nurse.
- It is the parent's responsibility to alert all other non-school programs of their child's health condition.
- Medical information may be shared with school staff working with your child and 911 staff, if they are called.
- I have reviewed the information on this health care plan and request/authorize trained school employees to provide this care in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- I understand this plan can only be discontinued by the LHP.
- I authorize the exchange of information about my child's health condition between the LHP office and the school nurse.
- *My signature below shows I have reviewed and agree with this health care plan.*

_____

Parent/Guardian Signature Date

For District Nurse's Use Only		
School Nurse Signature	**Date**	**Phone:**

Health care plan and medication (if prescribed) must accompany student on any field trip or school activity.
*****Keep plan readily available for substitutes.*****

(Spokane Public Schools Health Services revised 5/20)