Student Individual Emergency Medical Plan (IEMP)

Student's Name: _____ **Sex**:_____ **Birthday**_____

Parent's/Guardian's Name_____

Student's primary diagnosis or presenting problem: Describe characteristics of disorder and provide physician note of diagnosis and treatment and care while student at school. Ex. Seizure-what does it look like, peanut allergy-what happens, diabetes, severe asthmatic-describe symptoms.

1)

2)

3)

Allergies: Yes_____ No____ If yes, what is he/she allergic to and describe their reaction.

Medical History:

Onset of disorder/illness & last episode:

Current Medications: List any unusual behavior with medicines.

Medications	**Health Problem**	**How often**	**How given**	**Physician**
1.				
2.				
3.				
4.				
5.				

Student's primary care physician (not specialist):
Name:_____Phone:_____
Address:_____
May the school contact the physician in case there are questions or concerns in making an emergency care plan for your child? Yes_____ No_____

Emergency Plan
Please list below step by step plan of treatment for each health problem. Describe symptoms or behaviors. Usually these come from your physician and from your experience with your child. Please list symptoms when 911 is to be called based on your child's diagnosis or disorder.

Health Problem / disorder / symptoms	Directions for care
#1	**1.** 2. 3. 4.
#2	**1.** 2. 3. 4. 5.

Is your child prone to getting any particular health problem on a regular basis? Yes__ __ No___ Explain

Is there a special way your child behaves when he or she is about to become ill? Yes____No___ Explain

Please list specialists, clinics, therapists, or other physicians consulted for your child, the problems involved, and the dates of the most recent exam.

Doctor or Specialist	Problem	Date of last visit
1. 2. 3.		
4. 5.		

May the school nurse contact any of the above listed health professionals in the event of a concern or a question: Yes___ No ___

Comments or explanations of answers to any of the questions on this form:

The following procedures, ie gastric tube feeding, suctioning, use of VNS, etc are needed by my child at school following instructions from parents & or physician. Some procedures may be performed by classroom staff. List all procedures. Parents will provide all necessary equipment. Examples below as applicable:

Seizure and Respiratory management. Administration of Oxygen, and monitoring with pulse oximeter, G-tube feeds and medicine administration, SVN treatments, Chest percussion, etc.

_____

Parents please sign below and have physician sign.

_____ _____
Parent's / Guardian's Signature Date

_____ _____
Physician's Signature Date

Physician may fax info to nurse at Attention: Nurse, FAX: Phone:

Student:_____ Birthdate_____ Teacher_____

Discussed IEMP, as outlined by parent/guardian, with student's teacher.

Additional Information:

Date:_____

Nurse:_____

Teacher(s)/aide: _____ _____

_____ _____

_____ _____