Individual Health Plan/ Emergency Action Plan

Keller ISD Health Services Department

NAME: _____DOB: _____Teacher/Grade:_____

Emergency Contact #1: _____ Preferred Contact #:_____
Emergency Contact #2: _____ Preferred Contact #:_____
Physician Treating Condition: _____ Preferred Contact #:_____
Preferred Hospital: _____

DIAGNOSIS/CONDITION: _____

_____

_____

MEDICATIONS (separate form is required if administered during school):

Medication Name	Route	Dosage	Frequency	Home or School

Health Related Emergency/Accommodation Plan:

Individual Healthcare Plan: _____

Student Name_____ DOB: _____

PROCEDURE TO BE PERFORMED AT SCHOOL: (Special Procedure form is required)

Specific Procedure (s)	
Specific Instructions	
Equipment/ Location	
Precautions, unfavorable reactions	
Disposition of student After procedure	
Other	

Is procedure being delegated to unlicensed employee? Yes No

If yes, School Nurse must complete Delegation Training Documents and attach.

Trained Staff/ Location	
Trained Staff/ Location	
Buddy Nurse/ Location	

Parent Signature: _____ Date: _____

Registered Nurse Signature: _____ Date: _____

Licensed Vocational Nurse Signature: _____ Date: _____

☐ **Generic EAP electronically sent via Laserfiche to all staff directly involved with student services. Date: _____**