Whitehall-Coplay School District

Emergency Action Plan (EAP) - *Specified Condition*

Student: ___________________________________ Date: ____________________________

Teacher/Classroom: _______________________________

Allergies: ____

Physician/Healthcare Provider: ____

Hospital Preference: ____

TO BE COMPLETED BY PHYSICIAN/HEALTHCARE PROVIDER

Condition/Diagnosis: ____

Signs and Symptoms:

____

____

____

Treatment Plan for School and/or during an athletic event or after school activity:

1. ____
2. ____
3. ____
4. ____
5. ____

Medications:

____

____

Emergency Calls

1. Parent/Guardian: ____
2. Additional Contacts: ____

Physician Signature: _____________________________________ Date: ____________________

Parent Signature: ____ Date: __________________

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.***