Carolina Christian School

"He will teach us His ways so that we may walk in His paths" Micah $:2b

CCS MEDICAL ACTION PLAN

Action Plan forms are only required if a student has asthma, diabetes, seizures or severe allergies requiring an EpiPen. Section II of this form must be completed by the Physician.

SECTION I – PARENT OR GUARDIAN TO COMPLETE

Student Name: _____ _____

Last First Middle Date of Birth

_____ _____ _____

Parent/Guardian Cell Phone Work Phone

_____ _____ _____

Other Emergency Contact Cell Phone Work Phone

_____ _____

Treating Physician Phone

Student Medical Action Plan

☐ Severe Allergic Reaction ☐ Diabetes ☐ Other

☐ Asthma ☐ Seizure _____

Please describe the student's current medical condition, current treatment plan including medications and symptom management strategies, triggers, auras or initial symptoms of impending crisis.

_____

_____

_____

_____

_____

_____

Medications to be administered: (If Asthma, does inhaler need a spacer) _____

Additional Interventions to be considered (example diabetic oral intake) _____

_____

_____

_____

SECTION II – PHYSICIAN/ NURSE PRACTITIONER/ PHYSICIAN ASSISTANT TO COMPLETE

Effective Date: From _____ To _____

Check appropriate box:

Inject Epinephrine immediately, Call 911, monitor student and give additional antihistamines. -- SEVERE Symptoms:
Pale, blue, dizzy, obstructive swelling, confused, trouble breathing/swallowing, tight or hoarse throat, many hives over the body, vomiting, itchy face/mouth.

Give antihistamine, alert parent, monitor student. – MILD Symptoms:
Few hives, mild nausea, discomfort

☐ EpiPen
Give the pre-measured dose of 0.3 mg epinephrine by auto injection

☐ EpiPen Jr.
Give the pre-measured dose of 0.15 mg epinephrine by auto injection

☐ Antihistamine Brand or Generic: _____

Dose: _____

☐ Asthma Inhaler
☐ Spacer
☐ Frequency of doses _____

☐ Diabetic medications
☐ Glucagon (for blood sugar less than _____)

Dose_____

☐ Antiepileptic Medications _____

☐ Other: _____

Side effects of Medication _____

_____

Contraindications for Administration _____

_____

Additional information _____

_____

_____

_____

Can student self-administer ☐ Yes ☐ No

_____
PHYSICIAN/AUTHORIZATION SIGNATURE DATE

_____
PARENT/GUARDIAN AUTHORIZED SIGNATURE DATE

I hereby give permission for my child to receive medication during the school hours. I hereby release Carolina Christian School and its employees for any and all liability that may result from my child taking this prescribed medication. I am responsible for providing medication in the properly labeled pharmacy container with identifying information (child's name, medication, dosage, and time to be administered) All unused medications will be stored in the nurse's office or other delegated area and will be returned on the last day of school.