SCHOOL YEAR _____

Battle Ground School District Guidance for Non-Licensed School Personnel

Emergency Action Plan **HEART CONDITION** ***Confidential***

Student: _____ DOB: _____
Grade: _____ Teacher: _____ Room: _____ Ext: _____

PHOTO

Diagnosis: _____
Description of Condition:_____
_____
Limitations: ☐ Allow PE ☐ Allow Recess ☐ Allow student to gauge own activities

☐ **Student has dedicated Automatic External Defibrillator (AED)**
AED located:_____

Signs and Symptoms (can include ***any or all*** of the following)

- ➢Pain and/or heavy feeling in chest
- ➢Shortness of breath
- ➢Pale, clammy skin/sweating
- ➢Apprehension/anxiety
- ➢Dizziness, light headedness
- ➢Bluish lips, skin and/or nails
- ➢Nausea and/or vomiting
- ➢Other: _____
- ➢_____
- ➢_____
- ➢_____
- ➢_____

Severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation. Do not leave student alone.

ACTION FOR MILD SYMPTOMS

- Allow student to rest in place. Call office for prompt assistance.
- If AED prescribed, confirm location and availability
- Call RN or Building Administrator and Parent.
- Student may return to class if all signs and symptoms have resolved and student states he/she feels well.
- Other: _____

ACTION FOR MAJOR SYMPTOMS

- **If signs and symptoms do not resolve or worsen, call 911, building RN, and building Administrator.**
- **With loss of consciousness, call 911 and initiate CPR, if trained, or utilize AED, if prescribed.**
- Stay with student, reassure, keep warm and comfortable.
- Verify parent has been notified.

EDUCATIONAL / INDIVIDUAL CONSIDERATIONS
_____
_____
_____

Parent Signature: _____ Date: _____
Health Care Provider Name: _____ Date: _____
Health Care Provider Signature (optional): _____ Phone: _____ Fax: _____
RN Review: _____ Date: _____

Attention: Bus Drivers Activate Emergency Procedures: (Pull over, contact Dispatch to call 911) BUS#

School Name, Address, Phone Number

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

EMERGENCY CONTACTS

1) Parent/Guardian: _____
Relation: _____
Phone: _____

2) Parent/Guardian: _____
Relation: _____
Phone: _____

3) Emergency Contact: _____
Relation: _____
Phone: _____

4) Emergency Contact: _____
Relation: _____
Phone: _____

THIS SECTION BELOW TO BE FILLED BY THE SCHOOL NURSE

School Nurse: _____,
Phone: _____
Cell Phone: _____
The following School Staff are trained and delegated to Administer Medications and/or use AED:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Distribution: *This Emergency Action Plan (EAP) will be distributed to those school staff "who need to know." EAP has been distributed to (Initial):

____ Parent	Date: _____	____ Art	Date: _____
____ Physician	Date: _____	____ Librarian	Date: _____
____ Principal	Date: _____	____ Music	Date: _____
____ Kitchen/Food Services	Date: _____	____ Bus	Date: _____
____ Trauma Bag	Date: _____	____ Playground Aids	Date: _____
____ Teacher	Date: _____	____ Health Room	Date: _____
____ Teacher	Date: _____	____ Counselor	Date: _____
____ Teacher	Date: _____	____ Other	Date: _____
____ Teacher	Date: _____	____ Other	Date: _____
____ PE Teacher	Date: _____	____ Other	Date: _____

Additional Information