



Bethlehem Catholic High School

2133 Madison Avenue
Bethlehem, PA 18017
Fax: 610-866-4429

Becahi's Health Room

610-866-0791 ext. 328
nurse@becahi.org

GENERIC HEALTH PLAN for other health conditions

Student: _____ Gr/Teacher: _____ DOB/Age: _____

Emergency Contact #1: _____
Name Relationship Phone

Emergency Contact #2: _____
Name Relationship Phone

Physician's name: _____ Phone: _____

HEART CONDITION: ___ Yes ___ No

ORTHOPEDIC CONDITION: ___ Yes ___ No

OTHER HEALTH CONDITION: _____ **ACTIVITY LIMITS:** ___ Yes ___ No

ASSESSMENT DATA: (fill-in and check if applicable)

| Signs/Symptoms | Triggers | First Aid Interventions |
|----------------|-------------|-------------------------|
| — | — | — |
| — | — | — |
| — | — | — |
| — | — | — |
| Other _____ | Other _____ | Other _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Frequency of episodes: _____ Number of hospitalizations in past 12 months: _____

Current medications: (home (h) and school (s), including OTC and alternative meds)

| Name | Route | Dose | Frequency |
|------|-------|------|-----------|
| | | | |
| | | | |
| | | | |

For self-carry Medications:

- I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that he/she **SHOULD NOT** be allowed to carry and use that medication by him/herself.
- It is my opinion that _____ **SHOULD** carry his/her medication by him/herself.
 1. Student knows action of the medication and reason for taking medication.
 2. Student is aware of possible side effects of medication.
 3. Student agrees to never share medication with anyone.
 4. Student will always carry medication in correct container.
 5. Student agrees to go to the nurse's office if symptoms are not relieved by medication or if student has to use the medication more than twice in a day.

Physician's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Student's Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

GENERIC EMERGENCY ACTION PLAN

If any of the above conditions are not met, student will forfeit the right to carry and self-administer medication.

Student: _____ DOB/Age: _____

Emergency action is necessary when the student has symptoms such as _____

Steps to take during an episode:

1. Give medications if available.
2. Have student return to classroom if no longer in distress, symptoms have improved.
3. Contact parent if no improvement after medication or _____
4. **Seek emergency medical care if the student has any of the following:**
 - ✓ _____
 - ✓ _____
 - ✓ _____
 - ✓ _____
 - ✓ _____
 - ✓ _____
 - ✓ **Other** _____

IS A LIFE-THREATING ILLNESS DO NOT WAIT...

| | |
|---|---|
| TAKE THESE MEDICINES <u>NOW</u> AND CALL <u>911</u>. <ul style="list-style-type: none">• Medicine _____• Dosage _____• Route _____• Frequency _____• Other _____ | TAKE THESE MEDICINES <u>NOW</u> AND CALL <u>911</u>. <ul style="list-style-type: none">• Medicine _____• Dosage _____• Route _____• Frequency _____• Other _____ |
|---|---|

Special instructions:

Student Outcomes:

1. Student will participate in classroom/school activities with modifications as needed.
2. Student will improve or maintain understanding of checked items under Self Management skills.
3. Other: (describe) _____

Physician's Signature: _____ Date: _____
Parent's Signature: _____ Date: _____
Student's Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____