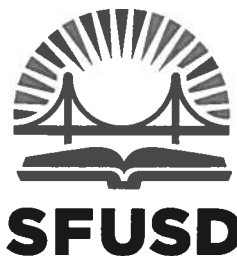


## Section B

### **EMERGENCY CARD PROCEDURE/ EMERGENCY CARE PLANS**

- Student Emergency/Medical Information Card – Processing Procedure
- Student Emergency/Medical Information Card:  
*English/Spanish/Chinese*
- Flow Chart – Student Emergency/ Medical Information Card and Student with a Medical Condition
- Letter to Parents regarding medical condition:  
*English/Spanish/Chinese*
- School Site List of Students Receiving Care for Medical Conditions
- Food Allergy Classroom Notification Letters WAD
- Allergy, Asthma, Diabetes, Seizure and Generic Emergency Care Plan: *English/Spanish/Chinese*
- Medication Form (one medication per form) (for Spanish and Chinese see Medication Administration section)





**SAN FRANCISCO  
PUBLIC SCHOOLS**

San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116  
Tel: 415-242-2615  
Fax: 415-242-2618  
[www.healthiersf.org](http://www.healthiersf.org)

## STUDENT EMERGENCY/MEDICAL INFORMATION CARD

### PROCESSING PROCEDURE

1. **All school sites must utilize the new Student Emergency/Medical Information Card available in English, Spanish, and Chinese.**
2. All students must have cards on file. [If a card is not found in your files- send a second card home]
3. Site employee (at the direction of the site administrator) will review cards and enter information into the database. (Student Information System). See page 2 "*Step By Step: Adding Medical Information to the SIS System.*"
4. Once data is entered School Secretary obtains report from SIS of all children with a medical condition.
  - Double click the reports button near the bottom of the Main Switch Board
  - Click Health from the report category
  - Select Medical Condition
  - Sort by: Alpha, grade, or homeroom
5. If the parent/guardian has indicated that the student has a medical condition the site will send the following appropriate information to the parent/guardian:
  - Cover letter to parent/guardian
  - Medication Administration Form
  - Emergency Care Plan (specific to condition indicated)

(Create a log to document when forms are sent to parent/guardian and follow-up efforts are made by school)
6. The forms/information will be returned to the school site. If the information is clear the site will begin implementation. [Notification of appropriate staff, administration of medication etc.]
7. If the site requires further directions the forms will be sent to School Health Programs Department-Nurse of the Day for review.

Student Emergency/Medical Information Card Processing Procedure  
Available @ <http://www.healthiersf.org/Forms/index.html>



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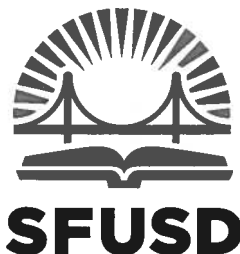
8. NOD will review the information and return plan implementation instruction to the school site.
9. Appropriate school site personnel will be informed of the medical condition/ medication requirement and the emergency care plan in an effort to ensure continuity of care.
10. School sites must complete the above procedures by October 1 of each school year.

**PLEASE BE ADVISED THAT VOLUNTEER WORKERS MAY NOT ASSIST  
IN THIS PROCESS due to Confidentiality.**

**STEP**  
*By*  
**STEP** Adding Information into the Medical  
Module (8) of the Student Information  
System (SIS) (See graphic on last page)

- Step 1** Login into the Student Information System (SIS) using your logon name and password.
- Step 2** Select the Student Records option from the Main Switch Board Menu.
- Step 3** The Student Roster will be presented. Double click the selected student from the school roster.
- Step 4** Turn EditsOn, using your mouse, right click on the tab Medical. This will display a floating menu, and then click the "AllowEdits" option with your left mouse button.
- Step 5** Select the Medical module tab number 8. Enter data (see table below). *(The Medical Module has fields to enter information from the Student Emergency/Medical Information Card; the Emergency Care Plan, 504 Plan and the Medication Administration Form.*

Student Emergency/Medical Information Card Processing Procedure  
Available @ <http://www.healthiersf.org/Forms/index.html>



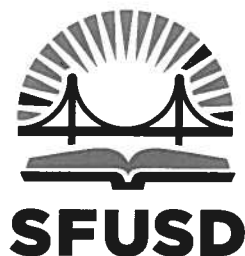
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<b>Medical Module (8)</b>		
<b>Field</b>	<b>Intent</b>	<b>Source of information</b>
Medical Form at school	Yes = Completed medication form at School	Medication Administration Form
Emergency Care Plan at school	Yes = Completed ECP at school	Emergency Care Plan
Emergency Plan Date	Date signed by health care provider and parent guardian.	Emergency Care Plan
Emergency Plan Loc.	Place the Emergency Care plan is kept.	Emergency Care Plan
504 Plan at school	Yes= Completed 504 plan at school	504 plan
504 Filed Date	Date 504 plan signed	504 plan
504 Plan Location	Where 504 plan kept	504 plan
Health Insurance	Does child have health insurance?	Student Emergency/Medical Information Card (back)
Medication at Home	Medication listed by parent/guardian.	Student Emergency/Medical Information Card (back)
Name of Medication	Name of medication listed by parent/guardian.	Student Emergency/Medical Information Card (back)

Student Emergency/Medical Information Card Processing Procedure  
Available @ <http://www.healthiersf.org/Forms/index.html>



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<b>Medical Module (8)</b>		
<b>Field</b>	<b>Intent</b>	<b>Source of information</b>
<b>Comments</b>	<b>Any additional comments re medical information</b>	<b>Student Emergency/Medical Information Card, Emergency Care Plan, 504 plan, Medication Form, etc.</b>
<b>Health Problem Type</b>	<b>Number from pull down menu</b>	<b>Student Emergency/Medical Information Card, Emergency Care Plan, 504 plan, etc.</b>
<b>Description</b>	<b>Name of condition corresponding to number on pull down menu</b>	<b>Student Emergency/Medical Information Card, Emergency Care Plan, 504 plan, etc.</b>
<b>Other Health Condition</b>	<b>Where to type in condition if "other medical condition" was chosen under Health Problem Type.</b>	<b>Student Emergency/Medical Information Card, Emergency Care Plan, 504 plan, etc</b>
<b>Medication at school</b>	<b>Yes=The medication the child is to take at school is on site.</b>	
<b>Self Administer</b>	<b>Yes= Health care provider and parent/guardian signed the may self administer box on the Medication Form.</b>	<b>Medication Administration Form</b>
<b>Name of Medication at school</b>	<b>Name of the medication to be taken at school.</b>	<b>Medication Administration Form</b>
<b>Other Medication</b>	<b>Second medication to be taken at school</b>	<b>Medication Administration Form</b>

Student Emergency/Medical Information Card Processing Procedure  
Available @ <http://www.healthiersf.org/Forms/index.html>



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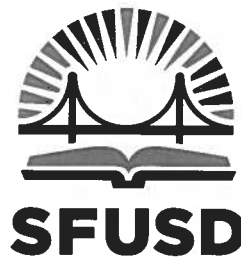
Fax: 415-242-2618

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<b>Medical Module (8)</b>		
<b>Field</b>	<b>Intent</b>	<b>Source of information</b>
<b>Allergy Type</b>	Choose from pull down menu	Student Emergency/Medical Information Card, Emergency Care Plan, 504 plan, etc
<b>Other Allergy</b>	If "other" was chosen in allergy pull down menu type allergy in here.	Student Emergency/Medical Information Card, Emergency Care Plan, 504 plan, etc
<b>How to give</b>	Route and way medication is to be given	Medication Administration Form, Health care provider section.
<b>Amount</b>	Amount of medication to give	Medication Administration Form, Health care provider section.
<b>When to give/repeat</b>	Time or situation when medication to be given	Medication Administration Form, Health care provider section also on Emergency Care Plan.
<b>Location of medication on site</b>	Where is the medication kept?	Emergency Care Plan
<b>Notes Date</b>	Date information entered in SIS	

**Step 7** If the child has a second medical condition go to bottom of page to **record** and click arrow to 2 second record and enter data.

**Step 8** There is no save option, once you have updated the student, you may continue by selecting another student from the Student Roster as indicated in Step 3.



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San Francisco Unified School District  
**2004 - 2005 Student Information System (SIS)**  
 Level: H Sch. Year: 2004 - 2005 Version: 3/17/2005  
 User: hawleyk Server: SURVEYOR Ver. Date: 5.205

**- INTERNATIONAL STUDIES ACAD**  
 Spring (2)

**School Roster: 624 INTERNATIONAL STUDIES ACAD**

lastname	firstname	studentno	sch	ac	gr	Counselor	Home	birthdate	sex
ADRIANA	MANEY	H00855580	624	A	12	FEATHER	20	4/1/1981	F
ADRIANA	MANEY	H08624103	624	A	12	FEATHER	20	9/12/1981	M
ADRIANA	MANEY	H02001798	624	A	12	FEATHER	19	12/23/1981	F
ADRIANA	MANEY	H08738213	624	A	12	FEATHER	21	8/6/1981	M
ADRIANA	MANEY	H08738212	624	A	11	FEATHER	21	2/23/1981	F
ADRIANA	MANEY	H00843740	624	A	09	FEATHER	22	2/21/1981	M
ADRIANA	MANEY	H00845101	624	A	09	FEATHER	100	11/30/1981	F
MICHAEL	TORVIL	H008447348	624	A	11	FEATHER	102	6/20/1988	M

**Student Record: MICHAEL TORVIL** (RUBENSI) Counselor: FEATHER Rm: 102 Sem: 2

1 Demographic 2 Contacts 3 Courses 4 Attendance 5 Programs 6 Confer 7 Health 8 Medical 9 Evt

StudentNo: H008447348 T523388088 Parent: [blank] Activity: A  
 Last Name: TORVIL Prefix: [blank] School No: 6  
 First Name: MICHAEL T. Street No: [blank] SubSchNo: [blank]  
 Preferred Name: [blank] Street: MOULTRIE SubSchNm: [blank]  
 Gender: M Suffix: ST

Select An Item  
 Vaccine  
 HVS Test  
**Medical**

**General Information** Year: 2005-2006

Medical Form at School [dropdown]  
 Emergency Plan at Sch [dropdown]  
 Emergency Plan Date: 5/5/2005  
 Emergency Plan Loc [dropdown]  
 504 Plan at School [dropdown]  
 504 Filed Date: 5/5/2005  
 504 Plan Location [dropdown]  
 Health Insurance [dropdown]  
 Medication At Home [dropdown]  
 Name Of Med At Home [text]  
 Comments [text area]

**Medication Information**

Health Problem Type [dropdown]  
 Description [text]  
 Other Health Condition [text]  
 Medication at School [dropdown] Self Admin [dropdown]  
 Name of Med At Sch [dropdown]  
 Other Medication [text]  
 Allergy Type [dropdown]  
 Other Allergy [text]  
 How To Give [text]  
 Amount [text]  
 When to Give/Repeat [text]  
 Location Of Med On Site [text]  
 Notes Date: 5/5/2005

Record: 1 of 1

Student Emergency/Medical Information Card Processing Procedure  
 Available @ <http://www.healthiersf.org/Forms/index.html>

**San Francisco Unified School District**      Date \_\_\_\_\_  
**STUDENT EMERGENCY / MEDICAL INFORMATION CARD**  
*(This card needs to be completed every school year)*

**NAME** \_\_\_\_\_ **HO#** \_\_\_\_\_  
(Last) (First) (Middle Initial)

School \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_ Home Room/Room \_\_\_\_\_

Birthdate 

Month		Day		Year			

 Sex: M % F %

Home Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_

Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Language Spoken at Home \_\_\_\_\_  
(If different from home address above)

Parent / Guardian / Caregiver Name _____	Parent / Guardian / Caregiver Name _____
Employer _____	Employer _____
Home Phone _____ Work Phone _____	Home Phone _____ Work Phone _____
Cell Phone _____ Pager No. _____	Cell Phone _____ Pager No. _____

CHILD LIVES WITH: % Mother % Father % Caregiver/Guardian % Other (specify) \_\_\_\_\_

**EMERGENCY CONTACTS** In case child listed above becomes ill or is injured at school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following:

#	Name	Relationship	Home Phone	Cell Phone
1.				
2.				
3.				

Health Care Provider \_\_\_\_\_ Phone \_\_\_\_\_

To assure prompt attention to your child, **PLEASE NOTIFY SCHOOL OF ANY CHANGE OF INFORMATION ON THIS CARD.**

English - STOCK #13-0700  
 Rev. 3/25/04, SFUSD-SSS (Rev. pdp)

**\*\*\*IMPORTANT: Please Complete Other Side of Card\*\*\***

My child has health insurance:  Yes  No

If YES, list: \_\_\_\_\_

Member # \_\_\_\_\_

Student Address Label

**NO MEDICAL CONDITION** OR

> **My child receives regular care for the following medical condition(s):**

Allergies/Allergic to: \_\_\_\_\_ Date of last reaction: \_\_\_\_\_

Requires Epinephrine (Circle one): YES NO

Asthma  Diabetes – Insulin required? (Circle one): YES NO  Seizures

-Does your child have any other major health issue(s)? Please list: \_\_\_\_\_

-Is your child taking medication(s)? Please list medication(s) and times taken:

Medications / times taken	Medications / times taken	Medications / times taken
-Other children attending SFUSD schools:		
Name	School	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____

**If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.**

\_\_\_\_\_  
Parent's/Guardian's Signature

**\*\*\*IMPORTANT: Please Complete Other Side of Card\*\*\***



Mi hijo/a tiene seguro de salud:  Sí  No  
Nombre del Seguro: \_\_\_\_\_  
Miembro # \_\_\_\_\_

Student Address Label

No tiene problemas médicos

▶ **Mi hijo/a recibe cuidado médico por las condiciones médicas siguientes:**

Alergias/Alérgico(a) a: \_\_\_\_\_ Fecha de la última reacción alérgica: \_\_\_\_\_  
Usa el medicamento Epinephrine (Encierre en un círculo su respuesta): Sí NO

Tipos de alergias: \_\_\_\_\_

Asma  Diabetes ▶ ¿Utiliza insulina? (Encierre en un círculo su respuesta): Sí NO  Ataques

▶ ¿Tiene su hijo/a algún problema médico serio? Por favor descríballo: \_\_\_\_\_  
\_\_\_\_\_

▶ ¿Está tomando algún medicamento su hijo/a? Anote los medicamentos y el horario cuando debe de tomarlos:

Medicamento / horario	Medicamento / horario	Medicamento / horario
▶ <u>Mis otros hijos que asisten a las escuelas del SFUSD son:</u>		
Nombre	Escuela	Grado
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Si mi hijo/a necesita que se le lleve a un lugar de emergencia, que sea al más cercano. Doy mi permiso para que las autoridades escolares tomen las medidas apropiadas para la seguridad y el bienestar de mi hijo/a.**

\_\_\_\_\_  
Firma del padre de familia o encargado

**\*\*\*IMPORTANTE: Por favor complete la información médica al dorso de esta tarjeta \*\*\***

三藩市聯合校區  
**學生緊急事故醫療資料卡**  
 (每學年需填寫一次這卡)

日期：\_\_\_\_\_

姓名 \_\_\_\_\_ 學號HO# \_\_\_\_\_

(姓) (名) (中間名)

學校 \_\_\_\_\_ 年級 \_\_\_\_\_ 報到室 \_\_\_\_\_

性別：男  女  出生日期 

--	--	--	--	--	--

在家所說語言 \_\_\_\_\_

住宅地址 \_\_\_\_\_ 公寓號碼 \_\_\_\_\_ 郵區編號 \_\_\_\_\_

郵寄地址 \_\_\_\_\_ 郵區編號 \_\_\_\_\_ 住宅電話 \_\_\_\_\_  
 (如跟住宅地址有別)

家長/監護人/ 看護人姓名 _____ 僱主 _____ 住宅電話 _____ 工作電話 _____ 手提電話 _____ 傳呼機號碼 _____	家長/監護人/ 看護人姓名 _____ 僱主 _____ 住宅電話 _____ 工作電話 _____ 手提電話 _____ 傳呼機號碼 _____
---	---

孩子與誰居住： 母親  父親  看護人/監護人  其他 (請說明) \_\_\_\_\_

**緊急聯絡人** 萬一上列孩子生病或在校受傷，而不能聯絡本人。學校當局得本人許可，聯絡及將本人子女交予下列任何一位的監護人：

	姓名	關係	電話號碼
1.			
2.			
3.			

孩子的兒科醫生 \_\_\_\_\_ 電話號碼 \_\_\_\_\_

為確保女孩得到即時照顧，這卡上的資料如有任何改變，請通知學校。

**\*\*\*重要：請填妥背面的醫療資料\*\*\***

我子女有醫療保險：有 沒有  
如有，請列出：\_\_\_\_\_

學生住址標籤

沒有醫藥狀況

▶ 我子女有以下醫藥狀況，定期接受護理：

過敏症 這些過敏症是否須要腎上腺素？（圈一個）：是 否

列出過敏症：\_\_\_\_\_ 上次病發日期：\_\_\_\_\_

哮喘  糖尿病 ▶ 是否須要胰島素？（圈一個）：是 否  奪取

▶ 你子女有任何其他主要健康問題嗎？請列出：\_\_\_\_\_

▶ 你子女有服用藥物嗎？請列出藥物及次數：

_____	_____	_____
藥物/次數	藥物/次數	藥物/次數

▶ 其他子女就讀三藩市聯合校區學校：

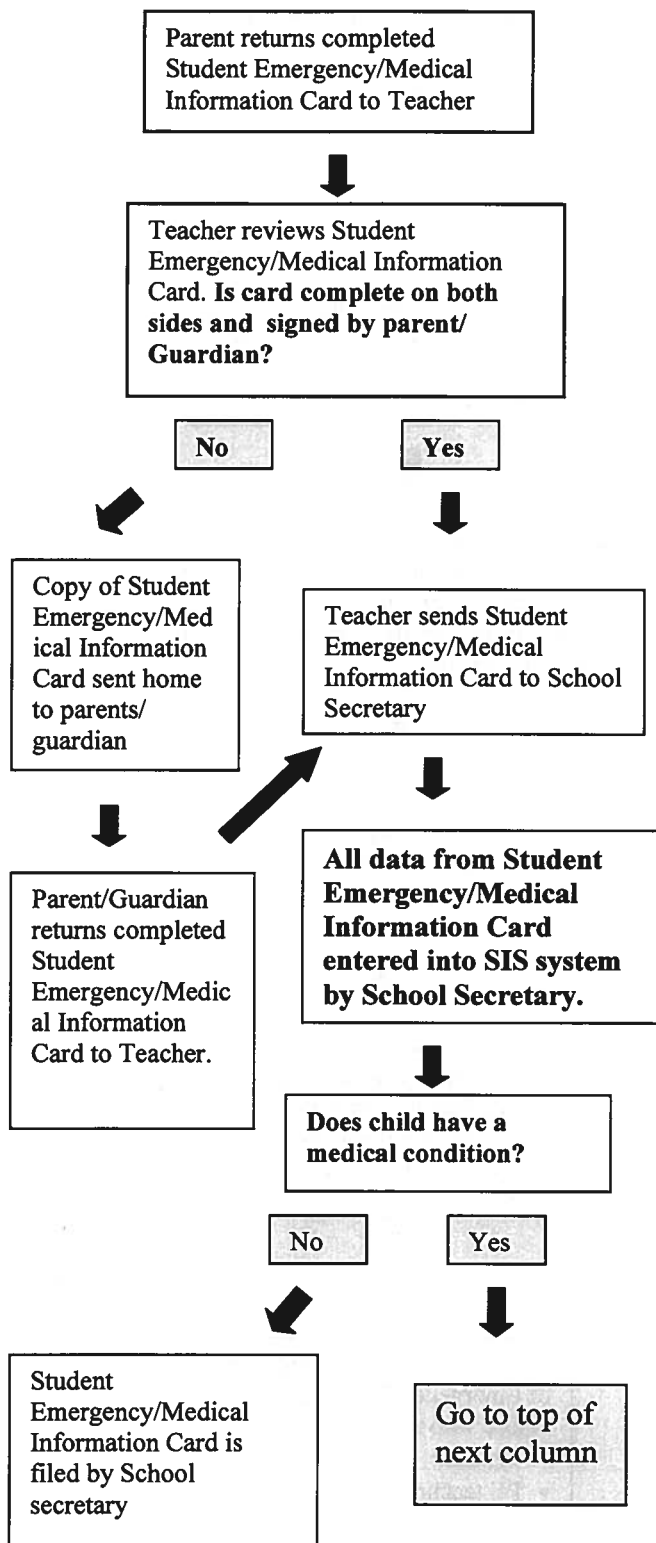
姓名	學校	年級
_____	_____	_____
_____	_____	_____
_____	_____	_____

如果本人子女需要被送入緊急醫院，他/她會被送去最近的醫院。本人授權學校當局為本人子女的安全和健康採取適當行動。

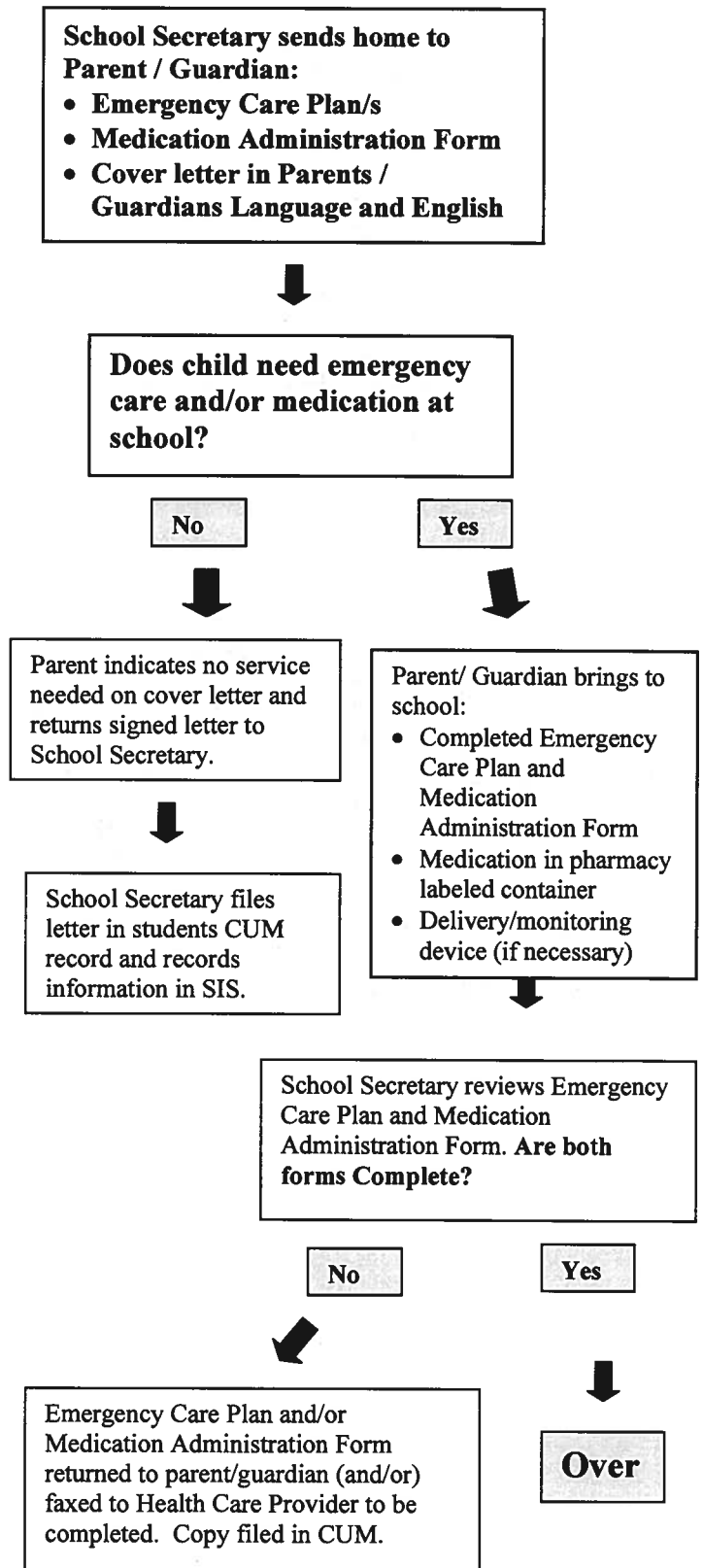
\_\_\_\_\_ 家長/監護人簽名

Rev. 11/12/02, SFUSD-SSS (Rev.pdp)

## Student Emergency/Medical Information Card



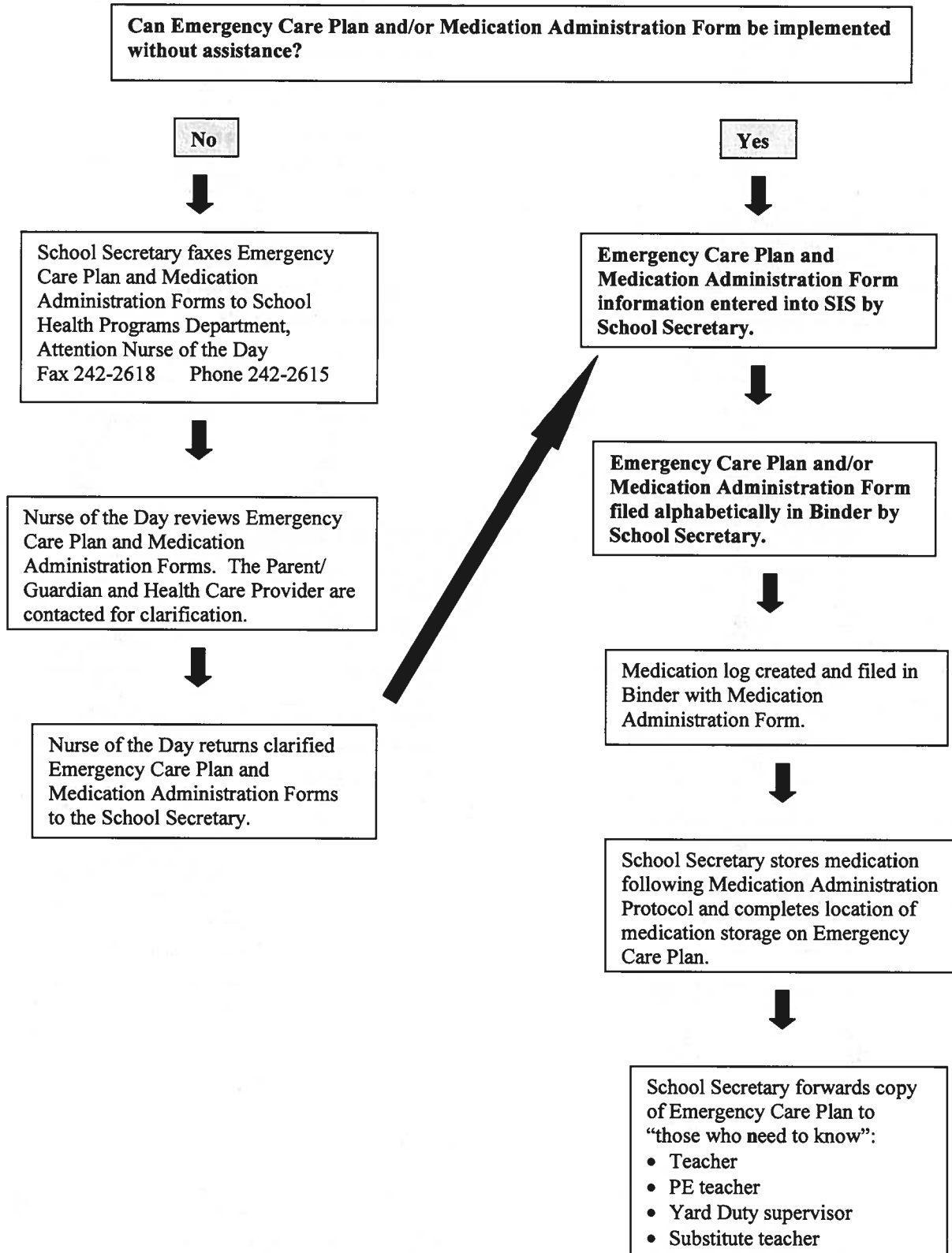
## Student With A Medical Condition



SFUSD Flow Chart for the review of Student Emergency/Medical Information Card, and Emergency Care Plans, Available @ <http://www.healthiersf.org/Forms/index.html>

(See Other Side First)

## Completed Emergency Care Plan / Medication Administration Form



SFUSD Flow Chart for the review of Student Emergency/Medical Information Card, and Emergency Care Plans,  
Available @ <http://www.healthiersf.org/Forms/index.html>

Dear Parent/Guardian:

Thank you for completing your child's **Student Emergency/Medical Information Card**. On the card you indicated your child has a medical condition/s. If this medical condition requires attention/assistance we ask that you;

- Have your child's health care provider complete and sign the attached
  - o **Emergency Care Plan** and
  - o **Medication Form** (if indicated).
  
- Complete and sign the parent/guardian sections of the attached
  - o Emergency Care Plan and
  - o Medication Form (if indicated)
  
- Please return the signed forms to your child's School Secretary.

Please be advised that:

- **No medication will be administered or can be self administered at school without Medication Administration Form completed and signed by your child's health care provider and you.**
- New Emergency Care Plans and Medication Administration Forms are required every school year.
- One Medication Administration Form is needed for each medication.
- The medication must be delivered to the school in a pharmacy labeled container with clear instructions.

The medical information will be shared only with school staff who, need to know to help ensure your child's health/safety.

If you feel that your child's medical condition does not need assistance at school please sign below and return this letter to the school.

- My child does not need services

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Child's School \_\_\_\_\_

Estimados padres de familia o encargados:

Gracias por completar la **Tarjeta de Emergencia/Información Médica del estudiante**. En una de las tarjetas indicaron que el estudiante tiene un problema que afecta su salud. Si este problema requiere atención/asistencia médica, les pedimos lo siguiente:

- El médico del estudiante debe de completar y firmar los documentos siguientes que se adjuntan
  - **Plan para el cuidado del estudiante en caso de emergencia**
  - **Formulario para que se administre el medicamento (si se indica).**
- El padre de familia o encargado debe de completar y firmar en las secciones correspondientes de los documentos adjuntos.
  - Plan para el cuidado del estudiante en caso de emergencia
  - Formulario para que se administre el medicamento (si se indica).
- Por favor, envíen estos documentos a la secretaria de la escuela.

Se les advierte que:

- **Si el médico no completa y firma el Formulario para que se Administre el Medicamento, no se le administrará o permitirá al estudiante que se auto administre ningún tipo de medicamento.**
- Cada año escolar se requiere que completen dos formularios: el del plan para el cuidado del estudiante en caso de emergencia y otro, para que se administre el medicamento.
- Se requiere un formulario por cada medicamento que se le debe de administrar.
- El medicamento se debe de entregar a la escuela en un envase con la etiqueta e instrucciones claras de la farmacia.

Con el propósito de proteger la salud y seguridad del estudiante, la información médica se compartirá solamente con el personal de la escuela que debe de estar enterado acerca de la misma.

Si ustedes creen que el estado de salud del estudiante no amerita la ayuda de la escuela, se les pide que por favor, firmen y devuelvan a la escuela la sección siguiente de esta carta.

- Mi hijo/a no necesita de estos servicios.

Nombre del estudiante \_\_\_\_\_ Fecha de nacimiento \_\_\_\_\_

Nombre del padre de familia o encargado \_\_\_\_\_

Firma del padre de familia o encargado \_\_\_\_\_ fecha: \_\_\_\_\_

Escuela a la que asiste el estudiante \_\_\_\_\_

5/05 Available @ [http://portal.sfusd.edu/template/default.cfm?page=chief\\_dev.health.MedicalForms](http://portal.sfusd.edu/template/default.cfm?page=chief_dev.health.MedicalForms)

親愛的家長／監護人：

多謝您填妥子女的**學生緊急事故卡／醫療資料卡**。在卡上，您表明子女有健康問題。若健康問題需要我們的注意或協助，請您：

- 要求子女的醫療保健提供者將以下附上的表格填妥並簽署：
  - 緊急護理計劃
  - 藥物服用表格（若有表明的話）
- 將表格上的家長／監護人部份填妥並簽署：
  - 緊急護理計劃
  - 藥物服用表格（若有表明的話）
- 將簽署好的表格交回子女學校的秘書。

請注意：

- 校方不會照顧您子女服用藥物或讓您子女自行在校服用藥物，除非子女的醫療保健提供者和您本人將藥物服用表格填妥並簽署好。
- 每學年必需有新的緊急護理計劃及藥物服用表格。
- 您需為每種藥物填寫一份藥物服用表格。
- 您交給校方的藥物必須是用藥房的藥瓶盛放，並且有清楚的標籤說明。

除了學校工作人員能獲悉這些醫療資料以確保您子女的健康和安全之外，資料是不會向其他人泄露。

若您覺得子女的健康問題並不需在校得到協助，請在下面簽名並將本信交回學校。

- 本人子女不需服務

子女姓名：\_\_\_\_\_ 子女出生日期：\_\_\_\_\_

家長／監護人姓名：\_\_\_\_\_

家長／監護人簽名：\_\_\_\_\_ 日期：\_\_\_\_\_

子女的校名：\_\_\_\_\_



Directive to Administrators (Specify which administrators)		WAD (Wednesday) Publication Date	WAD Notice ( Number )	No. of Pages
School site administrators		December 5, 2007		1 of 4
WAD Title ( Limit to 4-6 Words )			Date Due (if applicable)	Not Applicable After this Date:
Food Allergy Classroom Notification Letters				
From:	Title:	Signature:	Telephone:	
Meyla Ruwin	Director, School Health Programs Dept.		415-242-2615	
Inform:				
<input checked="" type="checkbox"/> Certificated Staff <input checked="" type="checkbox"/> Classified Staff <input type="checkbox"/> Parents <input type="checkbox"/> Post on Bulletin Board    Other _____				
<b>Administrative Directive</b>				
<b>WHAT:</b>	Food Allergy Classroom Notification Letters to parents/guardians informing them of the occurrence of food allergies in their child's classroom (available in English, Spanish and Chinese)			
<b>WHY:</b>	Parents/guardians of children with food allergies may request the classroom teacher notify the parents/guardians of their classmates to refrain from sending in foods for classroom parties/events that contain the identified substances.			
	<p><b>A request DOES NOT guarantee that food brought to school will be safe to ingest by those children with food allergies. In order for a child with food allergies to be safe at school, it is recommended that the child EAT ONLY FOOD BROUGHT FROM HIS/HER HOME.</b></p>			
<b>WHERE:</b>	Food Allergy Classroom Notification Letters will be available at the SHPD website, <a href="http://www.healthiersf.org">www.healthiersf.org</a> and will be included in the 2008-2009 School Health Manual.			
<b>WHEN:</b>	Classroom teachers and appropriate school staff should be made aware of a child's allergy to certain foods at the start of each school year and throughout the year if any new food allergies are identified.			
<b>HOW:</b>	When a child is identified with food allergies, the classroom teacher can notify the site administrator if the parents/guardians have requested classroom notification of the food allergies. The site administrator will complete and sign the letter(s), and give to the classroom teacher to sign and distribute to his/her class.			
<i>Approved</i>	Cabinet Member: <b>Trish Bascom</b>	Title: <b>Associate Superintendent, Student Support Services</b>	Signature:	
<b>SAN FRANCISCO UNIFIED SCHOOL DISTRICT - WEEKLY ADMINISTRATIVE DIRECTIVE (WAD)</b>				



San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116  
(415) 242-2615  
Fax. 242-2618  
www.healthiersf.org

Date:

Name of School: \_\_\_\_\_

Dear Parents/Caregivers of children in \_\_\_\_\_ class:  
(Name of teacher)

One or more of the children in this class has a severe allergy to \_\_\_\_\_

\_\_\_\_\_. Strict avoidance is the only way to prevent an allergic reaction. The allergies can be life-threatening.

We must do all we can to provide students with a safe learning environment. In an effort to allow the student(s) to participate fully in all activities, we ask that you **NOT** send in any foods that contain any of the above item(s) for class parties or other special events. Please include a list of all ingredients. Before preparing food that will be sent to a class party or event, it is necessary that cooking utensils and preparation surfaces that may have come in contact with the prohibited food item(s) listed above, be carefully washed to prevent cross contamination. It would be helpful if you let your child's teacher know a few days ahead if you plan on bringing "treats", so the food-allergic student(s) has the opportunity to provide his/her own treats.

Your cooperation will help keep these children healthy while at school.

Sincerely,

Teacher

Principal

10/07

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Distrito Escolar Unificado de San Francisco  
Departamento de Programas para la Salud Escolar  
1515 Quintara Street  
San Francisco, CA 94116  
(415) 242-2615  
Fax 242-2618  
www.healthiersf.org

Fecha:

Nombre de la escuela: \_\_\_\_\_

Estimados padres de familia o encargados de los estudiantes en la clase de: \_\_\_\_\_  
(Nombre del maestro/a)

Uno o más estudiantes de esta clase tienen alergia severa a \_\_\_\_\_

\_\_\_\_\_. Evitarla estrictamente es la única forma en que se previene una reacción alérgica. Las alergias pueden poner en peligro la vida de una persona.

Nosotros debemos de hacer todo lo que esté a nuestro alcance para proporcionar a los estudiantes un ambiente de aprendizaje seguro. En un esfuerzo que les permita al/los estudiante(s) participar de lleno en todas las actividades, les pedimos que a las fiestas del salón de clases u otros eventos especiales, **NO** envíen alimentos que contengan los ingredientes mencionados en la parte superior de esta carta. Por favor, incluyan una lista de los ingredientes. Antes de que preparen los alimentos que enviarán a una fiesta de la clase o algún evento, es necesario que limpien los utensilios y las superficies que probablemente están contaminados con los ingredientes prohibidos. Será de gran ayuda, si el maestro de su hijo/a está enterado con anticipación acerca de los refrigerios que planifican traer a la escuela, para que los estudiantes que son alérgicos, tengan la oportunidad de traer sus propios bocadillos.

Les pedimos su colaboración para que ayuden a que estos estudiantes se mantengan saludables.

Atentamente,

Maestro/a

Director/a

SHPD/10/07

Translation provided by SFUSD Translation Department

B-21



三藩市聯合校區  
學校健康計劃部  
地址：1515 Quintara St.  
San Francisco, CA 94116  
電話：415.242.2615  
傳真：415.242.2618  
網址：healthiersf.org

日期：\_\_\_\_\_

學校：\_\_\_\_\_

貴子弟就讀於\_\_\_\_\_的班級。  
(老師姓名)

近期該班有壹至多名學童被發現對\_\_\_\_\_有嚴重過敏。忌食該過敏性食物是唯一的預防方法。嚴重食物過敏可以致命。

我們會盡力為學生提供一個安全的學習環境。為求學生可以參與學校舉辦的活動，我們要求您不要攜帶上列的食物參加班級聯歡會或其他的任何特別活動。在您準備將會送往班級聯歡會的食物前，請知會我們有關食物的成份，並確保所有的烹飪器具和桌面都清洗乾淨，以防止受上列被禁止食物交叉污染。請您於數天前讓老師知道有關您所帶來的食物，好讓有食物過敏症的學生能有充足時間自備食物。

您的合作將有助促進學生的健康。

\_\_\_\_\_  
教師

\_\_\_\_\_  
校長

SHPD/10/07



To Be Completed by the Health Care Provider

# ALLERGY EMERGENCY CARE PLAN

*San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116-1273  
Tel: 415.242.2615 | Fax: 415.242.2618*

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_  
 Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_ (cell) \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_

**Attach Student Emergency Card for additional emergency contacts.**

Health Care Provider Treating Student for Allergy: \_\_\_\_\_ Ph: \_\_\_\_\_

**To provide assistance to a pupil experiencing an allergic reaction:**

<p>1. Type of allergy: _____</p> <p>2. Identify the triggers which start an allergic reaction: _____</p> <p>3. Possible allergic signs: _____</p> <p>OTHER: _____</p>	<p style="text-align: center;"><b><u>ACTIONS TO TAKE (Do this)</u></b></p> <p>Stay calm. Stay with the student and call for help. *Give medication (if prescribed). Name of med: _____ How to give: _____ Amount: _____ When to give/repeat: _____ Location of med: _____</p> <p>OTHER: _____ Notify parents/guardian, and document what happened in child's file. *By law a completed and signed Medication Form must be on file at the school before medication can be administered at school.</p>
---	--

**CALL 911 if student has**

- Difficulty breathing or noisy breathing
- Tightness of chest
- Swelling of tongue, eyes, or lips
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- A wheeze or persistent cough
- Loss of consciousness and/or collapse
- Vomiting, stomach cramps, or diarrhea
- Blue discoloration of lips or fingernails
- Become pale and floppy (young children)

**Administer CPR if breathing stops! Continue until paramedics arrive!**

**I authorize school personnel to implement this Allergy Emergency Plan as described.**

\_\_\_\_\_ Date \_\_\_\_\_  
 Health Care Provider Signature

**I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the authorized health care provider when necessary.  My child does not need services.**

\_\_\_\_\_ Date \_\_\_\_\_  
 Parent/Caregiver Signature



To Be Completed by the Health Care Provider

# ALLERGY EMERGENCY CARE PLAN

*San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116-1273  
TEL: 415.242.2615  
FAX: 415.242.2618*

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_  
 Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_ (cell) \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_

**Attach Student Emergency Card for additional emergency contacts.**

Health Care Provider Treating Student for Allergy: \_\_\_\_\_ Ph: \_\_\_\_\_

**To provide assistance to a pupil experiencing an allergic reaction:**

1. Type of allergy: _____ _____ 2. Identify the triggers which start an allergic reaction: _____ _____ 3. Possible allergic signs: _____ _____ OTHER: _____	<p style="text-align: center;"><b><u>ACTIONS TO TAKE (Do this)</u></b></p> Stay calm. Stay with the student and call for help. *Give medication (if prescribed). Name of med: _____ How to give: _____ Amount: _____ When to give/repeat: _____ Location of med: _____ OTHER: Notify parents/guardian, and document what happened in child's file. *By law a completed and signed Medication Form must be on file at the school before medication can be administered at school.
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**CALL 911 if student has**

- Difficulty breathing or noisy breathing
- Tightness of chest
- Swelling of tongue, eyes, or lips
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- A wheeze or persistent cough
- Loss of consciousness and/or collapse
- Vomiting, stomach cramps, or diarrhea
- Blue discoloration of lips or fingernails
- Become pale and floppy (young children)

**Administer CPR if breathing stops! Continue until paramedics arrive!**

**I authorize school personnel to implement this Allergy Emergency Plan as described.**

\_\_\_\_\_

Health Care Provider SignatureDate

**Doy mi consentimiento para que las autoridades escolares tomen la acción apropiada para la seguridad y bienestar de mi hijo/a. Doy mi consentimiento para que las autoridades escolares se comuniquen con el médico de mi hijo/a, cuando sea necesario. %o Mi hijo/a no necesita los servicios.**

\_\_\_\_\_

Firma del padre de familia o encargadoFecha



To Be Completed by the Health Care Provider

# ALLERGY EMERGENCY CARE PLAN

*San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116-1273  
TEL: 415.242.2615  
FAX: 415.242.2618*

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_  
 Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_ (cell) \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_

**Attach Student Emergency Card for additional emergency contacts.**

Health Care Provider Treating Student for Allergy: \_\_\_\_\_ Ph: \_\_\_\_\_

**To provide assistance to a pupil experiencing an allergic reaction:**

1. Type of allergy: _____ 2. Identify the triggers which start an allergic reaction: _____ 3. Possible allergic signs: _____ OTHER: _____	<p style="text-align: center;"><b><u>ACTIONS TO TAKE (Do this)</u></b></p> Stay calm. Stay with the student and call for help. *Give medication (if prescribed). Name of med: _____ How to give: _____ Amount: _____ When to give/repeat: _____ Location of med: _____ OTHER: _____ Notify parents/guardian, and document what happened in child's file. *By law a completed and signed Medication Form must be on file at the school before medication can be administered at school.
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**CALL 911 if student has**

- Difficulty breathing or noisy breathing
- Tightness of chest
- Swelling of tongue, eyes, or lips
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- A wheeze or persistent cough
- Loss of consciousness and/or collapse
- Vomiting, stomach cramps, or diarrhea
- Blue discoloration of lips or fingernails
- Become pale and floppy (young children)

**Administer CPR if breathing stops! Continue until paramedics arrive!**

**I authorize school personnel to implement this Allergy Emergency Plan as described.**

\_\_\_\_\_ Date

Health Care Provider Signature

本人同意，為了本人子女的安全和健康著想，學校當局可採取適當行動。本人同意，必要時，學校當局可與授權的健康護理員聯絡。 本人子女不需要服務。

\_\_\_\_\_ 日期

家長/看顧人簽名

日期



To Be Completed by the Health Care Provider

# ASTHMA EMERGENCY CARE PLAN

San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116  
Tel: 415.242.2615 | Fax: 415.242.2618

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ Room: \_\_\_\_\_  
Parent/Caregiver Name: \_\_\_\_\_ Phone (home) \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_  
Health Care Provider Treating Student for Asthma \_\_\_\_\_ Phone: \_\_\_\_\_

### To provide assistance to a pupil experiencing asthma symptoms.

<p><b><u>If you see or hear this</u></b></p> <ul style="list-style-type: none"> <li>Noisy breathing (wheezing)</li> <li>Coughing</li> <li>Shortness of breath</li> <li>Complaining of chest tightness</li> <li>or pressure on chest</li> <li>Difficulty breathing</li> </ul> <p>OTHER: _____</p> <p><b>Factors that may cause an asthma episode include:</b> cold weather, cigarette smoke, dust mites, exercise, respiratory infection, strong odor, pollens, mold, foods and/or OTHER: _____</p>	<p><b><u>Actions to Take</u></b></p> <ol style="list-style-type: none"> <li>Stay with student, speak softly, and stay calm</li> <li>Keep person sitting upright and encourage slow deep breathing—in through the nose &amp; out through puckered lips.</li> <li>Give quick relief medication: <i>(circle or write in)</i> Albuterol Inhaler 2 puffs with spacer; If symptoms improve, may repeat in 4 hours. Other: _____ <b>Location of med:</b> _____ <i>(School to complete)</i></li> </ol> <p><b>If symptoms continue, repeat in 5-10 minutes and have helper call 911. May repeat with 3-4 puffs every 20min x3 until medical help arrives.</b></p> <ol style="list-style-type: none"> <li>Have helper call parents/guardian/ and school nurse or Nurse of the Day (242-2615).</li> </ol> <p><i>*A completed and signed Medication Form must be on file at the school for each medication before medication can be administered at school.</i></p>
--	---

### CALL 911 IF YOU SEE

- Breathing difficulty remains or worsens
- Continuous spasmodic coughing
- Increasing anxiety or confusion
- Stooped body posture
- Struggling or gasping for breath
- Student having trouble talking or walking
- Skin pulling in around collarbone and ribs with breathing
- Student stopping play and not able to start activity again, due to breathing problems
- Lips or fingernails turning (darkening) grey or blue

### Administer CPR if breathing stops! Continue until paramedics arrive!

**Does student need medicine before PE/ recess?**  No  Yes Med Location \_\_\_\_\_  
As Needed?  No  Yes Always use before exercise?  No  Yes *(school to complete)*  
Med: *(circle or write in)* Albuterol Inhaler – 2 puffs with spacer, 15-20 minutes before exercise  
Other \_\_\_\_\_

I authorize school personnel to implement this Asthma Emergency Plan as described.

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

I give my consent for school authorities to take appropriate action for the safety and welfare of my child.  
I give my consent for school authorities to communicate with the authorized health care provider when necessary.  My child does not need services

\_\_\_\_\_  
Parent/Caregiver Signature

\_\_\_\_\_  
Date



To Be Completed by the Health Care Provider

# ASTHMA EMERGENCY CARE PLAN

San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116-1273  
TEL: 415.242.2615 FAX: 415.242.2618

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ Room: \_\_\_\_\_

Parent/Caregiver Name: \_\_\_\_\_ Phone (home) \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_

Health Care Provider Treating Student for Asthma \_\_\_\_\_ Phone: \_\_\_\_\_

### To provide assistance to a pupil experiencing asthma symptoms.

If you see or hear this	Actions to Take
<ul style="list-style-type: none"> <li>Noisy breathing (wheezing)</li> <li>Coughing</li> <li>Shortness of breath</li> <li>Complaining of chest tightness</li> <li>or pressure on chest</li> <li>Difficulty breathing</li> </ul> <p>OTHER: _____</p> <p>Factors that may cause an asthma episode include: cold weather, cigarette smoke, dust mites, exercise, respiratory infection, strong odor, pollens, mold, foods and/or OTHER: _____</p>	<ol style="list-style-type: none"> <li>Stay with student, speak softly, and stay calm</li> <li>Keep person sitting upright and encourage slow deep breathing—in through the nose &amp; out through puckered lips.</li> <li>Give quick relief medication: (<i>circle or write in</i>) Albuterol Inhaler 2 puffs with spacer; If symptoms improve, may repeat in 4 hours. Other: _____ Location of med: _____ <i>(School to complete)</i></li> </ol> <p>If symptoms continue, repeat in 5-10 minutes and have helper call 911. May repeat with 3-4 puffs every 20min x3 until medical help arrives.</p> <ol style="list-style-type: none"> <li>Have helper call parents/guardian/ and school nurse or Nurse of the Day (242-2615).</li> </ol> <p><i>*A completed and signed Medication Form must be on file at the school for each medication before medication can be administered at school.</i></p>

### CALL 911 IF YOU SEE

- Breathing difficulty remains or worsens
- Continuous spasmodic coughing
- Increasing anxiety or confusion
- Stooped body posture
- Struggling or gasping for breath
- Student having trouble talking or walking
- Skin pulling in around collarbone and ribs with breathing
- Student stopping play and not able to start activity again, due to breathing problems
- Lips or fingernails turning (darkening) grey or blue

### Administer CPR if breathing stops! Continue until paramedics arrive

Does student need medicine before PE/ recess?  No  Yes Med Location \_\_\_\_\_

As Needed?  No  Yes Always use before exercise?  No  Yes *(school to complete)*

Med: (*circle or write in*) Albuterol Inhaler – 2 puffs with spacer, 15-20 minutes before exercise

Other \_\_\_\_\_

I authorize school personnel to implement this Asthma Emergency Plan as described.

Health Care Provider Signature

Date

Doy mi consentimiento para que las autoridades escolares tomen la acción apropiada para la seguridad y bienestar de mi hijo/a. Doy mi consentimiento para que las autoridades escolares se comuniquen con el médico de mi hijo/a, cuando sea necesario. % Mi hijo/a no necesita los servicios.

Firma del padre de familia o encargado

Fecha



To Be Completed by the Health Care Provider

# ASTHMA EMERGENCY CARE PLAN

San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116-1273  
TEL: 415.242.2615 FAX: 415.242.2618

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ Room: \_\_\_\_\_  
 Parent/Caregiver Name: \_\_\_\_\_ Phone (home) \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_  
 Health Care Provider Treating Student for Asthma \_\_\_\_\_ Phone: \_\_\_\_\_

**To provide assistance to a pupil experiencing asthma symptoms.**

If you see or hear this	Actions to Take
<ul style="list-style-type: none"> <li>• Noisy breathing (wheezing)</li> <li>• Coughing</li> <li>• Shortness of breath</li> <li>• Complaining of chest tightness</li> <li>• or pressure on chest</li> <li>• Difficulty breathing</li> </ul> OTHER: _____  <b>Factors that may cause an asthma episode include:</b> cold weather, cigarette smoke, dust mites, exercise, respiratory infection, strong odor, pollens, mold, foods and/or OTHER: _____ _____	<ol style="list-style-type: none"> <li>1. Stay with student, speak softly, and stay calm</li> <li>2. Keep person sitting upright and encourage slow deep breathing—in through the nose &amp; out through puckered lips.</li> <li>3. Give quick relief medication: (<i>circle or write in</i>)              Albuterol Inhaler 2 puffs with spacer;              If symptoms improve, may repeat in 4 hours.              Other: _____  <b>Location of med:</b> _____  <i>(School to complete)</i> </li> </ol> <p><b>If symptoms continue, repeat in 5-10 minutes and have helper call 911. May repeat with 3-4 puffs every 20min x3 until medical help arrives.</b></p> <ol style="list-style-type: none"> <li>4. Have helper call parents/guardian/ and school nurse or Nurse of the Day (242-2615).</li> </ol> <p><i>*A completed and signed Medication Form must be on file at the school for each medication before medication can be administered at school.</i></p>

**CALL 911 IF YOU SEE**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Breathing difficulty remains or worsens</li> <li>• Continuous spasmodic coughing</li> <li>• Increasing anxiety or confusion</li> <li>• Stooped body posture</li> <li>• Struggling or gasping for breath</li> <li>• Student having trouble talking or walking</li> </ul> | <ul style="list-style-type: none"> <li>• Skin pulling in around collarbone and ribs with breathing</li> <li>• Student stopping play and not able to start activity again, due to breathing problems</li> <li>• Lips or fingernails turning (darkening) grey or blue</li> </ul> |
|--|--|

**Administer CPR if breathing stops! Continue until paramedics arrive**

**Does student need medicine before PE/ recess?**  No  Yes Med Location \_\_\_\_\_  
 As Needed?  No  Yes Always use before exercise?  No  Yes *(school to complete)*  
 Med: (*circle or write in*) Albuterol Inhaler – 2 puffs with spacer, 15-20 minutes before exercise  
 Other \_\_\_\_\_

**I authorize school personnel to implement this Asthma Emergency Plan as described.**

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

本人同意，為了本人子女的安全和健康著想，學校當局可採取適當行動。本人同意，必要時，學校當局可與授權的健康護理員聯絡。 本人子女不需要服務。

\_\_\_\_\_  
家長/看顧人簽名

\_\_\_\_\_  
日期



To Be Completed by the Health Care Provider

# DIABETES EMERGENCY CARE PLAN

San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116-1273  
Tel: 415.242.2615 | Fax: 415.242.2618

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_  
Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_  
Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_ (cell) \_\_\_\_\_

Attach Student Emergency Card for additional emergency contacts.

Health Care Provider Treating Student for Diabetes: \_\_\_\_\_ Ph: \_\_\_\_\_

**FOR SIGNS OF HYPOGLYCEMIA:** Headache, tremors, cold sweat, hunger, irritability, nervousness, pale skin, confusion, drowsiness, weakness or fatigue, dizziness, tingling lips, poor coordination, inability to concentrate, slurred speech, combativeness, uncooperativeness, convulsions, unconsciousness.

**Emergency medications/food:**

What to give	Amount	When to give
_____	_____	_____
_____	_____	_____

Location of medication/food: \_\_\_\_\_  
Student can return to the classroom when: \_\_\_\_\_

**CALL 911 WHEN:** \_\_\_\_\_

**FOR SIGNS OF HYPERGLYCEMIA:** Increased urination, increased thirst, blurred vision, increased hunger, fruity breath, vomiting, stomach pain, weakness, sleepiness, difficulty breathing, coma

Instructions for hyperglycemia: \_\_\_\_\_

**Emergency medication:**

What to give	Amount	When to give
_____	_____	_____
_____	_____	_____

Location of medication/food: \_\_\_\_\_  
Student can return to the classroom when: \_\_\_\_\_

**CALL 911 WHEN:** \_\_\_\_\_

- Contact parent/caregiver

A completed and signed Medication Form must be on file at the school before medication can be administered at school.

**I authorize school personnel to implement this Diabetic Emergency Plan as described above.**

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

**I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the authorized health care provider when necessary.  My child does not need services**

\_\_\_\_\_  
Parent/Caregiver Signature

\_\_\_\_\_  
Date



To Be Completed by the Health Care Provider

# DIABETES EMERGENCY CARE PLAN

San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116-1273  
TEL: 415.242.2615  
FAX: 415.242.2618

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_

Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_

Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_ (cell) \_\_\_\_\_

Attach Student Emergency Card for additional emergency contacts.

Health Care Provider Treating Student for Diabetes: \_\_\_\_\_ Ph: \_\_\_\_\_

**FOR SIGNS OF HYPOGLYCEMIA:** Headache, tremors, cold sweat, hunger, irritability, nervousness, pale skin, confusion, drowsiness, weakness or fatigue, dizziness, tingling lips, poor coordination, inability to concentrate, slurred speech, combativeness, uncooperativeness, convulsions, unconsciousness.

**Emergency medications/food:**

What to give	Amount	When to give
_____	_____	_____
_____	_____	_____
_____	_____	_____

Location of medication/food: \_\_\_\_\_

Student can return to the classroom when: \_\_\_\_\_

CALL 911 WHEN: \_\_\_\_\_

**FOR SIGNS OF HYPERGLYCEMIA:** Increased urination, increased thirst, blurred vision, increased hunger, fruity breath, vomiting, stomach pain, weakness, sleepiness, difficulty breathing, coma

Instructions for hyperglycemia: \_\_\_\_\_

**Emergency medication:**

What to give	Amount	When to give
_____	_____	_____
_____	_____	_____
_____	_____	_____

Location of medication/food: \_\_\_\_\_

Student can return to the classroom when: \_\_\_\_\_

CALL 911 WHEN: \_\_\_\_\_

- Contact parent/caregiver

A completed and signed Medication Form must be on file at the school before medication can be administered at school.

**I authorize school personnel to implement this Diabetic Emergency Plan as described above.**

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

**Doy mi consentimiento para que las autoridades escolares tomen la acción apropiada para la seguridad y bienestar de mi hijo/a. Doy mi consentimiento para que las autoridades escolares se comuniquen con el médico de mi hijo/a, cuando sea necesario.**  **Mi hijo/a no necesita los servicios.**

\_\_\_\_\_  
Firma del padre de familia o encargado

\_\_\_\_\_  
Fecha



To Be Completed by the Health Care Provider

# DIABETES

## EMERGENCY CARE PLAN

San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116-1273  
TEL: 415.242.2615  
FAX: 415.242.2618

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_

Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_

Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_ (cell) \_\_\_\_\_

Attach Student Emergency Card for additional emergency contacts.

Health Care Provider Treating Student for Diabetes: \_\_\_\_\_ Ph: \_\_\_\_\_

**FOR SIGNS OF HYPOGLYCEMIA:** Headache, tremors, cold sweat, hunger, irritability, nervousness, pale skin, confusion, drowsiness, weakness or fatigue, dizziness, tingling lips, poor coordination, inability to concentrate, slurred speech, combativeness, uncooperativeness, convulsions, unconsciousness.

**Emergency medications/food:**

What to give	Amount	When to give
_____	_____	_____
_____	_____	_____
_____	_____	_____

Location of medication/food: \_\_\_\_\_

Student can return to the classroom when: \_\_\_\_\_

CALL 911 WHEN: \_\_\_\_\_

**FOR SIGNS OF HYPERGLYCEMIA:** Increased urination, increased thirst, blurred vision, increased hunger, fruity breath, vomiting, stomach pain, weakness, sleepiness, difficulty breathing, coma

Instructions for hyperglycemia: \_\_\_\_\_

**Emergency medication:**

What to give	Amount	When to give
_____	_____	_____
_____	_____	_____
_____	_____	_____

Location of medication/food: \_\_\_\_\_

Student can return to the classroom when: \_\_\_\_\_

CALL 911 WHEN: \_\_\_\_\_

- Contact parent/caregiver

A completed and signed Medication Form must be on file at the school before medication can be administered at school.

I authorize school personnel to implement this Diabetic Emergency Plan as described above.

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

本人同意，為了本人子女的安全和健康著想，學校當局可採取適當行動。本人同意，必要時，學校當局可與授權的健康護理員聯絡。  本人子女不需要服務。

\_\_\_\_\_  
家長/看顧人簽名

\_\_\_\_\_  
日期



# SEIZURE EMERGENCY CARE PLAN

San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116-1273  
Tel: 415.242.2615 | Fax: 415.242.2618

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_

Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_ (cell) \_\_\_\_\_

Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_

Health Care Provider Treating Student for Seizure: \_\_\_\_\_ Ph: \_\_\_\_\_

**To provide assistance to a pupil experiencing a seizure:**

**If You See This**

Type of Seizure \_\_\_\_\_  
Triggers which start a seizure \_\_\_\_\_  
Possible seizure signs \_\_\_\_\_  
Usual length of seizure: \_\_\_\_\_  
Other: \_\_\_\_\_

**Do This**

- Help the student to the floor, and place student on his or her side, if drooling or vomiting.
- Clear any objects out of the way.
- Place something soft and flat under the student's head.
- Loosen any tight clothing.
- Don't put anything in the student's mouth.
- Monitor the student's breathing.
- Do not try to stop the seizure, or hold the child down
- Stay calm.
- Look at the clock and see how long the seizure lasts.
- Stay with the student until the seizure ends, comfort and allow him or her to rest afterwards.
- If the child had a febrile seizure, be sure to begin to cool the child with cool cloths.
- Reorient the child.
- Notify parents, and document what happened in child's file.
- OTHER: \_\_\_\_\_

**CALL 911 if...**

- Absence of breathing and/or pulse
- Seizure of 5 minutes or greater duration
- Two or more consecutive (without a period of consciousness between) seizures which total 5 minutes or greater
- Continued unusually pale or bluish skin/lips or noisy breathing AFTER the seizure has stopped

**I authorize school personnel to implement this Seizure Emergency Plan as described above.**

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

**I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the authorized health care provider when necessary.  My child does not need services**

\_\_\_\_\_  
Parent/Caregiver Signature

\_\_\_\_\_  
Date



To Be Completed by the Health Care Provider

# SEIZURE EMERGENCY CARE PLAN

San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116-1273  
TEL: 415.242.2615  
FAX: 415.242.2618

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_  
Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_ (cell) \_\_\_\_\_  
Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_  
Health Care Provider Treating Student for Seizure: \_\_\_\_\_ Ph: \_\_\_\_\_

## To provide assistance to a pupil experiencing a seizure:

### If You See This

Type of Seizure \_\_\_\_\_  
Triggers which start a seizure \_\_\_\_\_  
Possible seizure signs \_\_\_\_\_  
Usual length of seizure: \_\_\_\_\_  
Other: \_\_\_\_\_

### Do This

- Help the student to the floor, and place student on his or her side, if drooling or vomiting.
- Clear any objects out of the way.
- Place something soft and flat under the student's head.
- Loosen any tight clothing.
- Don't put anything in the student's mouth.
- Monitor the student's breathing.
- Do not try to stop the seizure, or hold the child down.
- Stay calm.
- Look at the clock and see how long the seizure lasts.
- Stay with the student until the seizure ends, comfort and allow him or her to rest afterwards.
- If the child had a febrile seizure, be sure to begin to cool the child with cool cloths.
- Reorient the child.
- Notify parents, and document what happened in child's file.
- OTHER: \_\_\_\_\_

### CALL 911 if...

- Absence of breathing and/or pulse
- Seizure of 5 minutes or greater duration
- Two or more consecutive (without a period of consciousness between) seizures which total 5 minutes or greater
- Continued unusually pale or bluish skin/lips or noisy breathing AFTER the seizure has stopped

**I authorize school personnel to implement this Seizure Emergency Plan as described above.**

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

**Doy mi consentimiento para que las autoridades escolares tomen la acción apropiada para la seguridad y bienestar de mi hijo/a. Doy mi consentimiento para que las autoridades escolares se comuniquen con el médico de mi hijo/a, cuando sea necesario. % Mi hijo/a no necesita los servicios.**

\_\_\_\_\_  
Firma del padre de familia o encargado

\_\_\_\_\_  
Fecha

Available @ <http://www.healthiersf.org/Forms/index.html>



SEIZURE
EMERGENCY CARE PLAN

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_
Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_ (cell) \_\_\_\_\_
Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_
Health Care Provider Treating Student for Seizure: \_\_\_\_\_ Ph: \_\_\_\_\_

To provide assistance to a pupil experiencing a seizure:

If You See This

Type of Seizure \_\_\_\_\_
Triggers which start a seizure \_\_\_\_\_
Possible seizure signs \_\_\_\_\_
Usual length of seizure: \_\_\_\_\_
Other: \_\_\_\_\_

Do This

- Help the student to the floor, and place student on his or her side, if drooling or vomiting.
Clear any objects out of the way.
Place something soft and flat under the student's head.
Loosen any tight clothing.
Don't put anything in the student's mouth.
Monitor the student's breathing.
Do not try to stop the seizure, or hold the child down.
Stay calm.
Look at the clock and see how long the seizure lasts.
Stay with the student until the seizure ends, comfort and allow him or her to rest afterwards.
If the child had a febrile seizure, be sure to begin to cool the child with cool cloths.
Reorient the child.
Notify parents, and document what happened in child's file.
OTHER: \_\_\_\_\_

CALL 911 if...

- Absence of breathing and/or pulse
Seizure of 5 minutes or greater duration
Two or more consecutive (without a period of consciousness between) seizures which total 5 minutes or greater
Continued unusually pale or bluish skin/lips or noisy breathing AFTER the seizure has stopped

I authorize school personnel to implement this Seizure Emergency Plan as described above.

Health Care Provider Signature

Date

本人同意，為了本人子女的安全和健康著想，學校當局可採取適當行動。本人同意，必要時，學校當局可與授權的健康護理員聯絡。 本人子女不需要服務。

家長/看顧人簽名

日期



# EMERGENCY CARE PLAN

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Rm: \_\_\_\_\_  
Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_ (cell): \_\_\_\_\_  
Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_

Attach Student Emergency Card for additional emergency contacts.

Health Care Provider Treating Student: \_\_\_\_\_ Phone: \_\_\_\_\_

**To provide assistance to a pupil experiencing symptoms related to a health condition:**

	<u>Action to Take</u>
1. Health Condition: _____	_____
2. Possible warning signs and symptoms: _____	_____
3. Current treatment, medications, & possible side-effects: _____	_____
4. Other: _____	_____

**CALL 911 if...**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I authorize school personnel to implement this Emergency Care Plan as described above.**

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

**I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the authorized health care provider when necessary.  My child does not need services**

\_\_\_\_\_  
Parent/Caregiver Signature

\_\_\_\_\_  
Date



To Be Completed by the Health Care Provider

# EMERGENCY CARE PLAN

San Francisco Unified School District  
Student Support Services Department  
1515 Quintara Street  
San Francisco, CA 94116-1273  
TEL: 415.242.2615  
FAX: 415.242.2618

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Rm: \_\_\_\_\_

Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_ (cell): \_\_\_\_\_

Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_

Attach Student Emergency Card for additional emergency contacts.

Health Care Provider Treating Student: \_\_\_\_\_ Phone: \_\_\_\_\_

**To provide assistance to a pupil experiencing symptoms related to a health condition:**

1. Health Condition: _____	<u>Action to Take</u>
2. Possible warning signs and symptoms: _____	_____
3. Current treatment, medications, & possible side-effects: _____	_____
4. Other: _____	_____

**CALL 911 if...**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I authorize school personnel to implement this Emergency Care Plan as described above.**

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

**Doy mi consentimiento para que las autoridades escolares tomen la acción apropiada para la seguridad y bienestar de mi hijo/a. Doy mi consentimiento para que las autoridades escolares se comuniquen con el médico de mi hijo/a, cuando sea necesario. % Mi hijo/a no necesita los servicios.**

\_\_\_\_\_  
Firma del padre de familia o encargado

\_\_\_\_\_  
Fecha



To Be Completed by the Health Care Provider

San Francisco Unified School District
Student Support Services Department
1515 Quintara Street
San Francisco, CA 94116-1273
TEL: 415.242.2615
FAX: 415.242.2618

EMERGENCY CARE PLAN

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Rm: \_\_\_\_\_
Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_ (cell): \_\_\_\_\_
Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_

Attach Student Emergency Card for additional emergency contacts.

Health Care Provider Treating Student: \_\_\_\_\_ Phone: \_\_\_\_\_

To provide assistance to a pupil experiencing symptoms related to a health condition:

Table with 2 columns: Health Condition (1-4) and Action to Take

CALL 911 if...

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

I authorize school personnel to implement this Emergency Care Plan as described above.

Health Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

本人同意，為了本人子女的安全和健康著想，學校當局可採取適當行動。本人同意，必要時，學校當局可與授權的健康護理員聯絡。 本人子女不需要服務。

家長/看顧人簽名 \_\_\_\_\_ 日期 \_\_\_\_\_

## San Francisco Unified School District – Student Support Services

### MEDICATION FORM (One Medication Per Form)

Dear Parent/Guardian/Caregiver:

California Education Code 49423 provides that students required to take medically prescribed or over-the-counter medications during the school day **MAY** be assisted by school personnel **ONLY** if the school district receives a specific written statement from the health care provider **AND** the parent/guardian/caregiver of the student. **Please complete this entire form and return it to the Principal.**

**IF POSSIBLE, PLEASE SCHEDULE MEDICATION OUTSIDE OF SCHOOL HOURS.**

**P l e a s e   p r i n t   l e g i b l y   i n   a l l   s e c t i o n s**

Student Name: Last	First	Middle	Date of Birth (Month/Day/Year)
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### HEALTH CARE PROVIDER SECTION

Health Condition for which medication is prescribed:	Medication: Dose: Frequency: _____ Duration: _____
How is medication to be given? <input type="checkbox"/> By mouth <input type="checkbox"/> Inhalation <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Other: _____	About what time does medication need to be given at school? _____ AM / PM
The medication is to be continued as above until: (please be as specific as possible about date)	Any precautions that school personnel need to know? Contraindications?
What are possible reactions/side effects?	What should be done in the event of reaction/side effect?
<p><b>Check appropriate boxes below:</b></p> <input type="checkbox"/> I authorize this student to <b>self-administer</b> the above medication. <input type="checkbox"/> I authorize designated school personnel to administer the above medication.	
Print name, address & phone number of Health Care Provider	Signature of Health Care Provider

### PARENT / GUARDIAN / CAREGIVER SECTION

Parent/Guardian/Caregiver Name	Home Language	Daytime Phone ( )
Address – Number and Street	Apt No.   City	Evening Phone ( )
School	Children’s Center / Elementary / Middle / High	School Hours
<p><b>Check appropriate boxes below:</b></p> <input type="checkbox"/> I permit my child to give himself/herself the above medication. <input type="checkbox"/> I permit designated school personnel to give my child the above medication.		

1. I agree to hold the San Francisco Unified School District (SFUSD) and its employees harmless from any and all liability for the results of taking the medication or the manner in which the medication is given.
2. I will reimburse the SFUSD and its employees for any liability arising out of these arrangements.
3. I will notify the Principal of the school immediately if there is a change in my child’s medication.
4. I understand it is my responsibility to send the medication to school in the **original pharmacy container** labeled with my child’s name and the health care provider’s instructions.
5. I understand that this form automatically expires at the end of each school year.
6. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.

See the following Medication Administration Section for more details

Parent/Guardian/Caregiver Signature \_\_\_\_\_ Date \_\_\_\_\_