To Be Completed by the Health Care Provider

EMERGENCY CARE PLAN

Student Last Name: _____ Student First Name: _____

Grade: _____ Age: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone (home): _____

Phone (Cell): _____ Phone (work): _____

Address (Street): _____ City: _____ ZIP _____

Health Care Provider Treating Student: _____ Phone: _____

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

1. Health Condition: _____	**Action to Take**
_____	_____
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 and to communicate with the authorized health care provider when necessary.

_____ _____

Parent/Guardian Signature Date