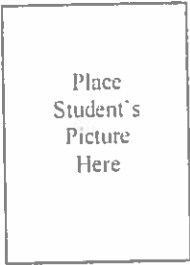


Emergency Healthcare Plan



Name: _____ DOB: _____

Teacher: _____ Grade: _____

Medical Condition: _____

Symptoms of Condition: _____

Action/Treatment: _____

Parent/Guardian/Relative Caregiver: _____ Phone: _____

Parent/Guardian/Relative Caregiver: _____ Phone: _____

Licensed Healthcare Provider: _____ Phone: _____

Emergency Contact: _____ Phone: _____

If symptoms of health problems above occur, the school nurse will assess the student and institute the prescribed action/treatment. The school nurse or designee will contact the parent/guardian/Relative Caregiver of the student. If a parent/guardian/Relative Caregiver cannot be reached, the emergency contact person will be called. Emergency personnel may be given a copy of this form.

Parent/Guardian/Relative Caregiver Signature: _____ Date: _____

Licensed Healthcare Provider Signature: _____ Date: _____