Emergency Care Plan
Individualized Health Care Plan

Student: _____ DOB:_____ School: _____Grade: ___

Parent/Guardian name: _____

Contact #'s: _____
Home Cell Work

Parent/Guardian name: _____

Contact #'s: _____
Home Cell Work

Physician's name: _____ Phone #: _____

Medical diagnosis/description: _____

_____

Medications: _____

Possible side effects: _____

STUDENT SPECIFIC EMERGENCY:

IF YOU SEE THIS:	**DO THIS:**
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

WHEN AN EMERGENCY OCCURS:

1. IF the emergency is life-threatening, **CALL 911 IMMEDIATELY.**
2. Stay with the student or designate another adult to do so.
3. Call or designate someone to call the school nurse and/or principal.
   a. State WHO you are.
   b. State WHERE you are.
   c. State WHAT the problem is clearly.

_____ _____
Physician's Signature/Date Teacher's Signature/Date

_____ _____
Parent's Signature/Date District Nurse's Signature/Date

_____
Principal's Signature/Date