

**Medical Emergency & Action Plan**

**THIS INFORMATION IS NEEDED TO PROVIDE CARE FOR YOUR STUDENT AT SCHOOL**

**PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN IT TO THE SCHOOL**

**STUDENT LAST NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.I. \_\_\_ FIRST NAME/NAME CALLED\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_**

**STUDENT ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT/GUARDIAN NAME(S) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1) PARENT/GUARDIAN NAME (RELATIONSHIP) AND NUMBER(S) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**2) PARENT/GUARDIAN NAME (RELATIONSHIP) AND NUMBER(S) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**EMERGENCY CONTACTS – NAME(S) AND NUMBER(S) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STUDENT’S PRIMARY DIAGNOSIS/ OTHER MEDICAL CONCERNS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ANY ALLERGIES? TYPE OF REACTIONS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**SEIZURE HISTORY/DETAILS IF RECENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**EMERGENCY ACTION PLAN**

**ACTIONS/INTERVENTION/PROCEDURES TO FOLLOW IN EVENT OF MEDICAL EMERGENCY**

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| **POSSIBLE PROBLEM/CONCERNS** | **SIGNS/SYMPTOMS THAT INDICATE MEDICAL PROBLEM** | **ACTION & INTERVENTIONS FOR SCHOOL NURSE AND/OR STAFF TO TAKE** |
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**~~~~~~PAGE 2~~~~~**

**LIST ALL MEDICATIONS STUDENT TAKES AT SCHOOL (S) AND AT HOME (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**STUDENT’S PRIMARY MD AND/OR PRIMARY SPECIALISTS ----- CONTACT INFORMATION ------ MOST RECENT VISIT**

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**ANY ADDITIONAL INFORMATION ABOUT YOUR STUDENT—INCLUDE ANY RECENT SURGERIES/DATES:**

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**IF 911 IS CALLED, AND THERE IS AN OPTION, HOSPITAL PREFERRED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IF ANY OF THIS INFORMATION CHANGES IN THE FUTURE, PLEASE NOTIFY EC SERVICES/EC NURSE**

**PLEASE SIGN BELOW, INDICATING YOUR CONSENT FOR THE EC NURSE**

**TO COMMUNICATE WITH YOUR CHILD’S HEALTH CARE PROVIDER.**

**PARENT/GUARDIAN SIGNATURE \_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_**

**SCHOOL NURSE SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLASSROOM TEACHER SIGNATURE (IF APPLICABLE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_**