______________________________ EMERGENCY ACTION PLAN

NAME: ____ Date of Birth: ____________

School: ________________ Grade: _____ Homeroom Teacher:______________________

Contact Information:
Parent/Guardian: ________________________ Telephone # (w) ____________________
Address: ______________________________ Telephone # (h) ____________________
Emergency Contact: ______________________ Telephone # ______________________

Physician Treating Student for (____________): ______________ Telephone # ____________
Other Physician: ____________________________________ Telephone # ____________

EMERGENCY PLAN **(Fill in blanks, cross out and initial any steps not needed for this student.)**

Emergency action is necessary when the student has symptoms such as ______________________, ____________________, ____________________, ______________________________.

Steps to take if any of the above listed symptoms occur:

STUDENT - SPECIFIC EMERGENCY PLAN

IF YOU SEE THIS:	DO THIS:

If student requires 911 services, transport to __________________ Hospital and contact parents/guardian

See reverse side for more instructions

Daily Management Plan

1. **Student's medical diagnosis: ____**

2. **Daily medication:**

   Name of medication: ______________________________ Dosage: _______ Time(s) of day: ____________

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   Name of medication: ______________________________ Dosage: _______ Time(s) of day: ____________

3. **Has this student ever been hospitalized for this medical condition? Yes _______ No _______**

   If yes, when? ____

3. **List activities or stressors that increase the symptoms. ____**

   ____

4. **This student CAN NOT participate in the following activities:**

Please note: If medications are to be taken at school, a Medication Authorization form must be completed by a parent/guardian and a physician.

Parent/Guardian Signature: ____ Date: ___________________

School Nurse Signature: ____ Review Date: ___________

THIS INFORMATION WILL BE SHARED WITH APPROPRIATE SCHOOL STAFF UNLESS OTHERWISE STATED.