Miscellaneous
Emergency Action Plan

Student Name:	School: Year:
Date of Birth:	Teacher: Grade:
Bus # AM Bus # PM	
Parent/Guardian #1:	Daytime phone #: Cell:
Parent/Guardian #2:	Daytime phone #: Cell:
Emergency Contact:	Daytime phone #: Cell:
Healthcare Provider:	Office #:

1. Name of medical condition? _____
2. Date of onset of medical condition: _____
3. Briefly describe symptoms? _____
_____
_____
4. Restrictions at school:_____
_____
5. Medications taken at home for this condition: _____
6. Medications needed at school for this condition: _____
_____
7. Actions school staff should take if symptoms occur: _____
_____
_____
_____

**This information will be shared with any school staff members as deemed necessary unless you state otherwise. I agree to inform school staff of any change in my child's health status that would warrant change in this action plan.*
☐***Yes*** ☐ ***No*** *I hereby authorize the school nurse or principal and the above physician to share information relative to the health of my child named above.*

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Office Use Only Notification to:

- ☐ Teacher
- ☐ Bus
- ☐ EAP/IHP Notebook
- ☐ Specials
- ☐ First Responders
- ☐ Original to Health Folder

To the Parents of

_____