MEDICAL EMERGENCY PLAN 2019-2020
Complete front and back of this form

Student: LAST NAME FIRST NAME MIDDLE DATE OF BIRTH

Address

Parents(s) Name(s)

Home Phone Mom Work Phone/Cell Dad Work Phone / Cell

Emergency Contact Name Emergency Contact Phone Number(s)

Student's Primary Physician Address Phone Number

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All Diagnosis/Medical Conditions:

Special Precautions/Concerns/Positions:

ALLERGIES: Please List / Type of Allergic Reaction:

Date of Last Seizure Details of Seizure

<u>All Medications that Student takes at Home (H) and School (S) - please List:</u>

++++++Continued on back - Please read and complete Page 2 of this form ++++++

Student Name

Insurance Company

Insured's Name

Insurance / Medicaid Number

Are there any physical signs/symptoms which precede serious medical incidents? If so please list:

List any special precautions/positions/medical and/or feeding concerns:

Examinations by medical specialists (vision, dental,neurologist,swallow study,etc)

Name of Provider	Date	Type of Exam

LISTED BELOW ARE THE SUGGESTED PROCEDURES TO BE FOLLOWED IN CASE OF A MEDICAL EMERGENCY INVOLVING THE ABOVE NAMED STUDENT. THESE PROCEDURES HAVE BEEN AGREED UPON BY BOTH STAFF AND THE CHILD'S PARENTS(UNLESS OTHERWISE NOTED:)

PREFERRED HOSPITAL? MOSES CONE HIGH POINT REGIONAL

We the Parents/Guardians shall be responsible for the payment of any and all medical fees, except where covered by insurance, including: Ambulance Fees, Hospitalization if recommended by the physician.

PARENT **Date**

TEACHER **Date**

PRINCIPAL **Date**