Guilford County Schools

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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 SCHOOL

STUDENT LAST NAME____________________________FIRST NAME_________________________ DATE OF BIRTH___/__/__

STUDENT ADDRESS____

PARENT/GUARDIAN NAME(S) ____

1) PARENT/GUARDIAN NAME (RELATIONSHIP) AND NUMBER(S) ____
____

2) PARENT/GUARDIAN NAME (RELATIONSHIP) AND NUMBER(S) ____
____

EMERGENCY CONTACTS – NAME(S) AND NUMBER(S) ____

STUDENT'S PRIMARY DIAGNOSIS/ OTHER MEDICAL CONCERNS ____
____
____

ANY ALLERGIES? TYPE OF REACTIONS ____
____

SEIZURE HISTORY/DETAILS IF RECENT ____
____

EMERGENCY ACTION PLAN

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

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

LIST ALL MEDICATIONS STUDENT TAKES AT SCHOOL (S) AND AT HOME (H) ____

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____
____
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____
____

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

____
____
____
____
____

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

____
____
____
____
____

 IF 911 IS CALLED, AND THERE IS AN OPTION, HOSPITAL PREFERRED? ______________________________

IF ANY OF THIS INFORMATION CHANGES IN THE FUTURE, PLEASE NOTIFY THE SCHOOL. PLEASE SIGN BELOW, INDICATING YOUR CONSENT FOR THE SCHOOL NURSE TO COMMUNICATE WITH YOUR CHILD'S HEALTH CARE PROVIDER.

PARENT/GUARDIAN SIGNATURE____DATE ________________

SCHOOL NURSE SIGNATURE ____DATE ________________

PRINCIPAL SIGNATURE ____ DATE ________________

THE FOLLOWING INFORMATION IS NOT REQUIRED, BUT MAY BE HELPFUL IN THE EVENT OF AN EMERGENCY:

INSURANCE COMPANY ___________________________________ NAME OF INSURED ___________________________________

INSURANCE POLICY NUMBER / MEDICAID NUMBER ____

4/2017