

EMERGENCY HEALTH PLAN

Name _____ ID# _____ Date _____

Diagnosis _____ Allergy _____

Physician's Name _____ Phone: _____

Student –Specific Emergencies

<i>If You See This</i>	<i>Do This</i>

If an emergency occurs at a time or place other than normal school hours:

1. Call **911** immediately if life threatening
2. Stay with student or designate another adult to do so.
3. Give prescribed medication if available.

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911

Medication: _____ Dosage _____ Method of Admin: _____

Medication: _____ Dosage _____ Method of Admin: _____

Instructions: _____

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature and may be shared with school personnel if necessary to assure the health of the student.

Parent Signature *Date* *Physician Signature* *Date*

Emergency Contacts (please print)

1. Name: _____ Relationship: _____

Phone#1: _____ Phone #2 _____

2. Name: _____ Relationship: _____

Phone#1: _____ Phone #2 _____

3. Name: _____ Relationship: _____

Phone#1: _____ Phone #2 _____