EMERGENCY HEALTH CARE PLAN

Student's Name: _____

Date of Birth: _____

Student's Grade:_____ Teacher: _____

This Emergency Health Care Plan is to be signed and dated by a parent/guardian and physician. Without a parent/guardian and physician signature, this Heath Care Plan is not valid. All medical supplies ore to be provided by the family.

CONTACT INFORMATION: *(in order of priority)*

Contact Name 1:	Phone #:	Alternate #:	Relationship to Student:
Contact Name 2:	Phone #:	Alternate #:	Relationship to Student:
Contact Name 3:	Phone #:	Alternate #:	Relationship to Student:

MEDICAL DIAGNOSIS/CONDITION(S):

Signs & Symptoms:
If symptoms occur, follow these step by step Instructions:
Additional Notes/Instructions:

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

Symptoms of an Allergic Reaction:

MOUTH	Significant swelling of the tongue or Lips
THROAT	Tight or hoarse throat, trouble breathing or swallowing
SKIN	Many hives over body, widespread redness
GUT	Repetitive vomiting, severe diarrhea
LUNG	Shortness'of breath, wheezing, repetitive cough
HEART	Pale or bluish skin, faintness, weak pulse, dizziness

**The severity of symptoms can quickly change. All above symptoms can potentially progress to life-threatening situations!*

If medication Is to be used at school for the above condition, a Request for Administration of Medication (5330-F1) form will need to be completed, signed, and dated by the physician/licensed prescriber AND parent/guardian.

A Request for Release of Information form should also be completed and signed by parent/guardian. I agree with the provided plan as written and for school staff to share this information with those that need to know. I give my permission to use my child's picture on this plan (if I did not supply a photo) and for staff to contact the treating health care professional for clarification of this plan, if needed.

Parent Name:

Parent Signature: Date:

Physician Name:

Physician Signature: Date:

Fax#