HEALTH SERVICES

EMERGENCY CARE PLAN

Student's Name:	**ID No:**	**DOB:**
Diagnosis:		**Grade:**
Date Plan was Developed:		**SCHOOL:**
Father:	**Home Phone:**	**Work Phone:**
Mother:	**Home Phone:**	**Work Phone:**
Emergency Contact:	**Home Phone:**	**Work Phone:**
Emergency Contact:	**Home Phone:**	**Work Phone:**
Physician:		**Office Phone:**
Diet Prescription for Meals at School:		
Current Medication:		
****Copy of Physician Orders Attached****		**Allergies:**

If you see this:	Do this:

The following staff members are trained to deal with an emergency, and initiate the appropriate procedures:

1. _____ 2. _____ 3. _____ 4. _____

_____ _____
Registered Nurse's Signature Date

Bus: ____ Yes ____ No ** Notify Kitchen: ____ Yes ____ No