



# EMERGENCY ACTION PLAN

## Health Condition \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Picture	<b>Contact Information:</b>	
	Parent/Guardian Name: _____	Phone: _____
	Parent/Guardian Name: _____	Phone: _____
	Emergency Contact: _____	Phone: _____
	Additional Contacts: _____	Phone: _____

Building Health Office/School Nurse: \_\_\_\_\_ Phone: \_\_\_\_\_

### AN EMERGENCY MAY INCLUDE ANY OR ALL OF THESE SYMPTOMS:

\_\_\_\_\_

If you see this:	DO THIS:

Preferred hospital: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Plan written by: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*The parent/guardian signature authorizes the nurse to share this information with school staff on a "need to know" basis. In the event of an emergency, care will be initiated and parents will be contacted.*

This plan is in effect for the current school year only.