EMERGENCY HEALTH CARE PLAN

STUDENT _____DATE_____

DATE OF BIRTH _____HEIGHT_____WEIGHT_____

PARENT(S)/GUARDIAN(S)_____

EMERGENCY CONTACT NUMBER(S): please list if cell/work/home and who's number it is

_____

_____

PRIMARY CARE PHYSICIAN:_____PHONE NUMBER:_____

HEALTH INSURANCE/MEMBER ID:_____

DIAGNOSIS:_____ ANY TRIGGERS:_____

ALLERGIES: YES/NO (please circle) If yes, please explain:_____

MEDICATIONS: (please list name, strength, when taken and how taken): _____

_____

_____

_____

_____

SIGNS OF EMERGENCY:_____

_____

_____

ACTIONS FOR SCHOOL STAFF TO TAKE: _____

_____

_____

_____

PHYSICIAN SIGNATURE_____DATE_____

PARENT/GUARDIAN SIGNATURE_____DATE_____