

*\*\*Please complete both sides of this form.\*\**

## **EMERGENCY HEALTH CARE PLAN**

### **Part One: (Parent to complete)**

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Emergency contacts:

Mother (H) \_\_\_\_\_ (W) \_\_\_\_\_ Cell \_\_\_\_\_

Father: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Cell \_\_\_\_\_

I understand it is my responsibility to provide the school nurse with my child's medication(s) and the complete medication orders from the physician. If not provided, I understand no medication can be administered and 911 will be called.

**Parent's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

### **Part Two: (Physician to complete)**

Student has Asthma?    yes    no      Medication needed in school?    yes    no

Student's Allergy: \_\_\_\_\_

Is this child at high risk for a severe allergic reaction?    yes    no

### **PHYSICIAN ORDERS:**

1. If ingestion/exposure is suspected and the following symptoms are noted:

Administer: **MEDICATION:** \_\_\_\_\_

**EXACT DOSAGE:** \_\_\_\_\_ **Route** \_\_\_\_\_

2. If allergic reaction continues and/or the following symptoms are noted:

Administer: **MEDICATION:** \_\_\_\_\_

**EXACT DOSAGE:** \_\_\_\_\_ **Route** \_\_\_\_\_

**CALL 911**

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Physician's Phone # \_\_\_\_\_