EMERGENCY ACTION PLAN

Student's Name______________________________DOB_____________

Teacher/Grade____

Parent/Guardian____

Address____

Home Phone___________________Work Phone________________

Phone number parents can be reached during school hours:
mom_____________________dad__________________________

Hospital Preference_______________________ Phone #__________

Physician's Name_________________________ Phone #_________

Alternate Contact person_________________ Phone #__________

Medical Condition____

Medication taken **Dosage (time & amount)**

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EMERGENCY CARE STEPS

If you see this **Do this**

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Parent's Signature________________________ Date_____________