



## EMERGENCY PLAN FOR OTHER MEDICAL CONDITIONS

<b>Student's Name:</b> _____ Date of Birth: _____	School: _____ Teacher: _____ Grade: _____
<b>Parent/Guardian:</b> _____ Ph-H: _____ Address: _____ Ph-W: _____ _____ Postal C: _____ <b>Parent/Guardian:</b> _____ Ph-H: _____ Address: _____ Ph-W: _____ _____ Postal C: _____ <b>Emergency Contacts:</b> Relationship: _____ _____ Ph-H: _____ Ph-W: _____ _____ Ph-H: _____ Ph-W: _____ <b>Doctor:</b> _____ Ph: _____ Address: _____ Postal C: _____	<b>Place Student's Photograph Here</b>
Name of medical condition(s): _____ _____ Describe: _____ _____ _____ What symptoms might your child experience while at school? _____ _____ _____ What symptoms may require emergency care _____ _____ _____ If these symptoms occur, what care do you want your child to receive? _____ _____ _____ <b>The Designated First Aider will be called and 911 may be activated for ambulance.</b>  If your child requires medications while at school, you will have to complete a Medication Administration form (available at the school). Name of Medication(s): _____ _____ _____ Does your child wear a Medic Alert bracelet? _____	

**RETURN FORM TO SCHOOL AND DISCUSS WITH ALL YOUR CHILD'S TEACHERS.**

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