EMERGENCY ACTION PLAN

Student:_____ **Date of Birth: _____ Teacher: _____Grade: ____**	**Medical Diagnosis: _____** **Allergies: _____**
Physician:_____ **Phone:_____** **Preferred hospital: _____**	**Parent Contact: _____** **Home: _____** **Cell:_____Work:_____** **Other: _____**

Plan for (specify condition):	
If you see this:	**Do this:**
If you see this: Student specific emergency	**Do this:**

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL THE RESCUE SQUAD EVEN IF PARENTS CAN NOT BE REACHED!

This emergency action plan was prepared by the following nurse:

RN's signature:_____

RN's print name:_____

Date: _____