MEDICAL CONDITION EMERGENCY CARE PLAN 2016-2017 SCHOOL YEAR
GREENFIELD-CENTRAL COMMUNITY SCHOOL CORPORATION

Student's Name: _____ Date of Birth: _____

Student's Address: _____

EMERGENCY CONTACTS

Name	Relationship	Telephone	Email
1.			
2.			
3.			

TO BE COMPLETED BY THE PHYSICIAN

This student has the following medical condition that may require rapid response from school personnel:

_____

Due to this condition, the student may exhibit or experience the following symptoms:

_____

If the student suffers from any of the symptoms listed above, follow the instructions listed below (medications require Form 5330F1 and/or 5330 F1b to be completed):

1. _____
2. _____
3. _____
4. _____
5. _____

This medical condition becomes life-threatening if:

_____

Call 911 immediately if the student experiences any of the life-threatening symptoms listed above, and notify parent.

Comments/Special Instructions:

_____

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Telephone Number: _____

(-OVER-)

TO BE COMPLETED BY THE PARENT/GUARDIAN

In addition to the above instructions from the physician, I wish to communicate the following information to school personnel regarding my student:

_____

_____

_____

As the parent/guardian of a student with a medical condition, I understand it is **my** responsibility to inform bus drivers, coaches, extra-curricular sponsors, tutors, etc., of my student's condition.

I agree to and wish to implement this emergency care plan for my student. My student understands the importance of reporting symptoms immediately to the school health assistant.

I hereby give permission for the exchange of medical information between the corporation nurse, health assistant, school principal, and the physician listed above. I also give permission for clinic personnel to share this medical information with school staff as needed to help protect my student's safety and well-being.

Parent/Guardian's Signature: _____ Date: _____

Printed Name: _____

TO BE COMPLETED BY SCHOOL PERSONNEL

Date ECP received by clinic personnel: _____

□ ECP Reviewed by Health Assistant _____

□ ECP Reviewed by Corporation Nurse _____