



To Be Completed by the Health Care Provider

San Francisco Unified School District  
Student Support Services  
1515 Quintara Street  
San Francisco, CA 94116-1273  
Tel: 415.242.2615 | Fax: 415.242.2618

# EMERGENCY CARE PLAN

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Rm: \_\_\_\_\_  
Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_ (cell): \_\_\_\_\_  
Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_

**Attach Student Emergency Card for additional emergency contacts.**

Health Care Provider Treating Student: \_\_\_\_\_ Phone: \_\_\_\_\_

**To provide assistance to a pupil experiencing symptoms related to a health condition:**

	<u>Action to Take</u>
1. Health Condition: _____	_____
2. Possible warning signs and symptoms: _____	_____
3. Current treatment, medications, & possible side-effects: _____	_____
4. Other: _____	_____

**CALL 911 if...**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I authorize school personnel to implement this Emergency Care Plan as described above.**

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

**I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the authorized health care provider when necessary.  My child does not need services**

\_\_\_\_\_  
Parent/Caregiver Signature

\_\_\_\_\_  
Date