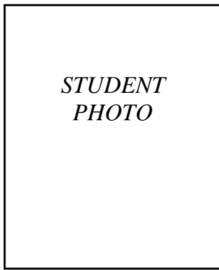

EMERGENCY CARE PLAN

San Francisco Unified School Distirct
Student, Family, and Community Support Department
School Health Programs
1515 Quintara Street
San Francisco, CA 94116-1273
Tel: 415.242.2615 | Fax: 415.242.2618

For School Use Only
Location of Medication: ____________________

TO BE COMPLETED BY PARENT/CAREGIVER

Name: ________________________ Date of Birth: ____________ School: ________________

Grade:______ Homeroom Teacher: ______________________ Room: _________

Parent/Caregiver Name: ______________________ Phone (home): ________________ (cell):___________

Address: ________________________ Phone (work): _____________ Email:________________

------------TO BE COMPLETED BY THE HEALTH CARE PROVIDER------------

Health Care Provider Treating Student for Allergy:______________________________ Ph: ______________

Health Condition:____

Student's most common symptoms/warning signs: ______________________________

Student's current treatment, medications & possible side effects: ______________________

ACTIONS TO TAKE

- **Stay calm**
- **Stay with the student**
- **Give medications as indicated below**

List actions to take below

CALL 911 if student has

-
-
-
-
-

Administer CPR if Breathing Stops!
Continue Until Paramedics Arrive!

Notify parents/guardian and document what happened in the First Aid and Medication Logs.
***By law, a completed and signed Medication Form must be on file at the school before medication can be administered at school.**

I authorize school personnel to implement this Emergency Plan as described.
I have completed the medication form(s) FOR EACH medication listed above.

______________________________ ______________
Health Care Provider Signature **Date**

本人同意，為了本人子女的安全和健康著想，學校當局可採取適當行動。本人同意，必要時，學校當局可與授權的健康護理員聯絡。

______________________________ ______________
家長/看顧人簽名 日期