



# EMERGENCY CARE PLAN

San Francisco Unified School District  
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: \_\_\_\_\_ Ph: \_\_\_\_\_  
Health Condition: \_\_\_\_\_  
Student's most common symptoms/warning signs: \_\_\_\_\_  
Student's current treatment, medications & possible side effects: \_\_\_\_\_

### ACTIONS TO TAKE

(list actions to take below)

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- 
- 
- 

### CALL 911 if student has

List signs and symptoms that indicate an emergency: <ul style="list-style-type: none"><li>•</li><li>•</li><li>•</li><li>•</li></ul>	<b>Administer CPR if Breathing Stops!</b> <b>Continue Until Paramedics Arrive!</b>
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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 a medication form 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