STUDENT PHOTO

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:_____ 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)

-
-
-
-

CALL 911 if student has

List signs and symptoms that indicate an emergency:

-
-
-
-

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 a medication form FOR EACH medication listed 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 to communicate with the authorized health care provider when necessary.

_____ _____
Parent/Caregiver Signature **Date**