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)

-
-
-
-

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.**

CALL 911 if student has

List signs and symptoms that indicate an emergency:	**Administer CPR if Breathing Stops! Continue Until Paramedics Arrive!**
• • • •	

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**

Doy mi consentimiento para que las autoridades escolares tomen la acción apropiada para la seguridad y bienestar de mi hijo/a. Doy mi consentimiento para que las autoridades escolares se comuniquen con el médico de mi hijo/a, cuando sea necesario.
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_____ _____
Firma del padre de familia o encargado **Fecha**