**SHIOCTON AREA SCHOOL DISTRICT**
***School Health Services***

# HEALTH MANAGEMENT AND EMERGENCY PLAN

**Student**_____**DOB**_____ **Grade/Teacher**_____

**Parent**_____ **Home Phone**_____ **Work Phone**_____

**Physician**_____**Clinic**_____ **Physician Phone**_____
**Emergency Contact**_____ **Relationship**_____ **Phone H**_____**W**_____
**Hospital of Choice for Emergency Care**_____

**Plan effective dates:**_____**through**_____ **School Nurse**_____

**MEDICAL DIAGNOSIS/HEALTH CONCERN:**

**DATE OF DIAGNOSIS:**_____

**SYMPTOMS REQUIRING EMERGENCY CARE:**

**ACTION TO BE TAKEN FOR EMERGENCY CARE:**

- ❑ **MEDICATION (refer to Medication Administration Consents):**_____
  _____
- ❑ **CALL 911:**_____

**OTHER**_____

**Parent/Guardian Signature (indicates consent)**_____ **Date**_____