



San Francisco Unified School District
School Health Programs Department
1515 Quintara Street
San Francisco, CA 94116-1273
TEL: 415.242.2615
FAX: 415.242.2618

EMERGENCY CARE PLAN

Name: _____ Grade: _____ Age: _____ Date of Birth: _____

School: _____ Homeroom Teacher: _____ Rm: _____

Parent/Caregiver Name: _____ Phone (home): _____ (cell): _____

Address: _____ Phone (work): _____

Attach Student Emergency Card for additional emergency contacts.

Health Care Provider Treating Student: _____ Phone: _____

To provide assistance to a pupil experiencing symptoms related to a health condition:

| | <u>Action to Take</u> |
|---|-----------------------|
| 1. Health Condition: _____ | _____ |
| 2. Possible warning signs and symptoms: | _____ |
| _____ | _____ |
| 3. Current treatment, medications, & possible side-effects: _____ | _____ |
| _____ | _____ |
| 4. Other: _____ | _____ |
| _____ | _____ |

CALL 911 if...

I authorize school personnel to implement this Emergency Care Plan as described 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 for school authorities to communicate with the authorized health care provider when necessary. My child does not need services

Parent/Cargiver Signature

Date