

EMERGENCY CARE PLAN**School Year:**

Student:	Birthdate:
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Emergency Numbers:

Name	Home	Work	Cell/Pager

Physician:	Specialist	Other:
Phone:	Phone:	Phone:
Preferred hospital in case of emergency:	Phone:	Medical Insurance / ID #:

Medical Diagnosis:
Medical Procedures/Needs:

Routine Medications given at home and at school:

Medication	Dosage	Route	Time Given

Allergies:
Nutrition/Meal Preparation:
Meal Times:
Student specific behaviors:

Student Specific Emergency Procedures:

If you see this:	Do this:

Emergency Back-up Plan:

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