TSD Emergency Action Plan*

*May supplement an Individualized Education Plan (IEP) or 504 Plan

Please Print

Pupil's Name | Birthdate | Home Phone

Parent/Guardian Name | Work Phone (Mother) | Work Phone (Father)

PERSONS TO BE NOTIFIED IN CASE OF EMERGENCY:

Name | Relationship | Phone

Name | Relationship | Phone

CONTACT PHYSICIAN(S):

1st Choice | Phone | 2nd Choice | Phone

DIAGNOSIS: _____

MEDICATION:	DOSAGE/TIME GIVEN:
1.	
2.	
3.	
4.	

ALLERGIES:	MEDICATION / TREATMENT:
1.	
2.	
3.	
4.	

EMERGENCY ACTION PLAN STEPS:

☐ Please check here if any information continued on reverse side *

My signature indicates my involvement in this plan and I provided the information above.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

EmergencyEAP:8-12-09

Emergency Action Plan...Continued

Please Print

☐ YES ☐ NO

If the parents and authorized physician named on this form cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, do you authorize and direct the school authorities to send the pupil (*properly accompanied)* for treatment to the hospital most easily accesible?

☐ YES ☐ NO

Do you agree to be financially responsible for all expenses incurred for treatment under the circumstances described above?

Name of Insurance Company: _____ I.D. # _____

If the answers to any of the above questions are NO, please explain below what action you desire school authorities to take.

_____
_____
_____
_____
_____
_____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

Additional Information

Note: Please use this space for additional information as denoted by checking the box on the front of this form.

_____
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