

NASD Emergency Health Care Plan

School: _____

Student: _____ Grade: _____ Date: _____

Parent/Guardian: _____

Phone: _____ Phone: _____

Parent/Guardian: _____

Phone: _____ Phone: _____

Other Emergency Contact: _____

Phone: _____

Physician: _____

Phone: _____

DIAGNOSIS: _____

Symptoms Requiring Treatment/Care: _____

TREATMENT/PLAN OF CARE: _____

Medications: _____

Location of Meds at School: _____

Classroom Accommodations: _____

Other Accommodations (class trips, testing, etc): _____

Activity Restrictions: _____

Circumstances Requiring Parent Notification: _____

Parent Signature

Date

Physician Signature

Date

Principal Signature

Date

School Nurse Signature

Date