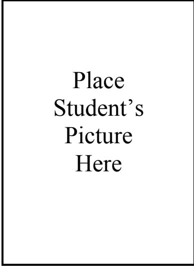
John Dickinson High School
Emergency Healthcare Plan



Name:______________________________________ DOB:_____________

Teacher:____________________________________ Grade:____________

Medical Condition:____

Symptoms of Condition:____

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Action/Treatment:____

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Parent/Guardian/Relative Caregiver:__________________________________ Phone:____________________

Parent/Guardian/Relative Caregiver:__________________________________ Phone:____________________

Physician:____ Phone:____________________

Emergency Contact:____ Phone:____________________

If symptoms of health problems above occur, the school nurse will assess the student and institute the prescribed action/treatment. The school nurse or designee will contact the parent/guardian/Relative Caregiver of the student. If a parent/guardian/Relative Caregiver cannot be reached, the emergency contact person will be called. Emergency personnel may be given a copy of this form.

Parent/Guardian/Relative Caregiver Signature:_______________________________ Date:________________

Physician Signature:____ Date:________________