STUDENT ACTION PLAN

Name_____DOB_____

Address_____Grade____ Teacher_____

Parent/Guardian: _____

Phone (h) _____ (c) _____ (w) _____

Other Contact_____Phone _____

Health Care Provider:_____Phone_____

Special Health Needs/Procedures/Medications:

1. _____
2. _____
3. _____

Action Plan

If you see this:	Do This:

If an Emergency Occurs:

1. Stay with the child.
2. Call or designate someone to call the nurse—**State who you are, where you are, what the problem is.**
3. The nurse will assess the child and decide whether the emergency plan should be implemented.

Emergency Plan

1. Activate Medical Response Team.
2. Call 911.
3. Call parent.

_____ _____ _____

School Nurse Phone Number Date

_____ _____

Parent Signature Date Physician Signature Date

(For secondary students, a list of all teachers will be attached. A copy of the care plan will be provide to each teacher.)

Reviewed 8.2018