Hutchinson Public and Parochial Schools - Health Services

Emergency Care Plan

School Year _____

Student _____ DOB _____ Grade/Room _____

Emergency Contact	Relationship	Phone	Phone

Health/Medical Condition	
Signs/Symptoms	
Emergency Response	
Medications	

Comments	

** I understand by signing this form, I authorize the school to administer the medication(s) according to standard school policy. I give permission for the LSN or building nurse to contact my child's health care provider regarding this plan and/or medication, and to communicate with my child's teachers, bus company, athletic director and/or other school personnel regarding my child's health condition(s) as deemed necessary. I release school personnel from liability in the event of adverse reactions resulting from this medication. I understand that administration of medication may not necessarily be done by a nurse. I authorize my child to self-administer his/her medication if deemed appropriate by LSN, parent and health care provider.*

Parent/Guardian Signature _____ Date _____

Physician/Provider Signature _____ Date _____

Printed Name _____ Clinic _____

Licensed School Nurse Signature _____ Date _____