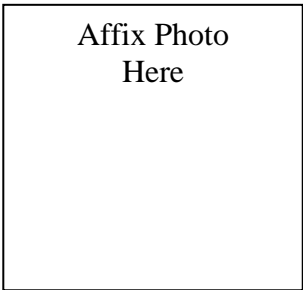




STUDENT HEALTH PLAN 2024 Emergency Response Plan



Student Name: _____

Date of Birth: _____ **School Year:** _____

Medical Condition/Allergy: _____

Prescribed Medication: _____

Symptoms/signs to watch for: _____

Management Plan:

Step 1: _____

Step 2: _____

Step 3: _____

Parent Contacts:

Name: _____ **Phone:** _____

Relationship: _____

Name: _____ **Phone:** _____

Relationship: _____

Doctor Details:

Name: _____ **Phone:** _____

Address: _____