

**MEDICAL CONDITION EMERGENCY CARE PLAN 2022-2023 SCHOOL YEAR  
GREENFIELD-CENTRAL COMMUNITY SCHOOL CORPORATION**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student's Address: \_\_\_\_\_

**EMERGENCY CONTACTS**

<u>Name</u>	<u>Relationship</u>	<u>Telephone</u>	<u>Email</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____

**TO BE COMPLETED BY THE HEALTHCARE PROVIDER**

This student has the following medical condition that may require rapid response from school personnel:  
\_\_\_\_\_

Due to this condition, the student may exhibit or experience the following symptoms: \_\_\_\_\_

If the student suffers from any of the symptoms listed above, follow the instructions listed below (medications require Form 5330F1 and/or 5330 F1b to be completed):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

This medical condition becomes life-threatening if:  
\_\_\_\_\_

Call 911 immediately if the student experiences any of the life-threatening symptoms listed above, and notify parent.

Comments/Special Instructions:  
\_\_\_\_\_

Healthcare Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

HCP's Printed Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**TO BE COMPLETED BY THE PARENT/GUARDIAN**

In addition to the above instructions from the HCP, I wish to communicate the following information to school personnel regarding my student:

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As the parent/guardian of a student with a medical condition, I understand I should inform bus drivers, coaches, extra-curricular sponsors, tutors, etc., of my student's condition.

I agree to and wish to implement this emergency care plan for my student. My student understands the importance of reporting symptoms immediately to the school health assistant.

I hereby give permission for the exchange of medical information between the corporation nurse, health assistant, school principal, and the healthcare provider listed above. I also give permission for clinic personnel to share this medical information with school staff as needed to help protect my student's safety and well-being.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**TO BE COMPLETED BY SCHOOL PERSONNEL**

Date ECP received by clinic personnel: \_\_\_\_\_

ECP Reviewed by Health Assistant \_\_\_\_\_

ECP Reviewed by Corporation Nurse \_\_\_\_\_