MEDICAL CONDITION EMERGENCY CARE PLAN 2025-2026 SCHOOL YEAR
GREENFIELD-CENTRAL COMMUNITY SCHOOL CORPORATION

Student's Name: _____ Date of Birth: _____

EMERGENCY CONTACTS

Name	Relationship	Telephone
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 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 the parent.

Comments/Special Instructions:

_____

Healthcare Provider's Signature: _____ Date: _____

HCP's Printed Name: _____ Telephone Number: _____

*****THIS IS A 2-SIDED FORM - BOTH SIDES MUST BE COMPLETED FOR THE PLAN TO BE IMPLEMENTED*****

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:

_____

_____

_____

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 with 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 school nurses, health assistants, 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 clinic personnel and PowerSchool Medical Alert updated or confirmed:

_____ _____

Date Signature

□ ECP Reviewed by Corporation Nurse:

_____ _____

Date Signature

Notes from clinic personnel regarding this plan (if necessary):