

**MEDICAL CONDITION EMERGENCY CARE PLAN 2026-2027 SCHOOL YEAR
GREENFIELD-CENTRAL COMMUNITY SCHOOL CORPORATION**

Student's Name: _____ Date of Birth: _____

EMERGENCY CONTACTS

<u>Name</u>	<u>Relationship</u>	<u>Telephone</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 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

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 permit the exchange of medical information between school nurses, health assistants, the school principal, and the healthcare provider listed above. I also permit 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: _____