Grandville Public Schools

Health Room Office
4700 Canal SW
Grandville, Michigan 49418
Phone: (616) 254-6455 Fax : (616) 254-6462

Emergency Health Care Plan

Part 1: Completed by Parents

Name: _____ Date: _____

Student Building: _____ Grade: _____

Emergency Health Concern: _____

Factors that trigger Health Concern: _____

Symptoms that develop: _____

Part 2: Completed by parents and physician and signed by physician. (NOTE! Care likely to be provided by *non-medical* staff). If medication administration is part of the plan, please specify the following information: Name of medication, specific dosage, route, and indications for use. Medications will be kept in a central location in the office unless specifically noted by physician that they should be carried by student or kept in another location.

ACTIONS to TAKE:

1. _____
2. _____
3. _____
4. _____

Physician Signature: _____ Date: _____

Type/Print Physician Name: _____ Phone: _____

Part 3: Completed by Parents

I hereby request and authorize school personnel to follow the steps above as outlined by my physician, including the administration of medications if indicated. School personnel may contact the office of my child's physician for concerns relating to this plan. I understand that I must bring the medication to school myself, (unless there is physician permission to self-administer) and that a new form must be completed for changes and/or additions.

Signed: _____ Date: _____

Emergency Contacts (Names and contact information):

_____

_____

Part 4: Completed by Staff

This document received on _____ (date) by _____ (Name)

____ Copy sent to school nurse_____ Copies made for staff_____

Location of Emergency Meds: _____ **If Epi., Exp. Date:** _____

NOTES

DATE	TIME	TALKED TO	COMMENTS