



**504.1.3 - Medical Emergency Procedures**

**Student Information:**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Grade/Class: \_\_\_\_\_  
Classroom Teacher: \_\_\_\_\_ ASN: \_\_\_\_\_

**Medical Diagnosis or Condition:**

Description/Explanation:

**Family Contact Information:**

Parent/Guardian: _____	Phone #:	Home: _____	Work: _____	Cell: _____
Parent/Guardian: _____	Phone #:	Home: _____	Work: _____	Cell: _____

**If above are not available contact:**

Contact Name:: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Hospital/Clinic Contact Information:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Emergency Procedures:**

**Reaction Symptoms/Signs:**

**Procedure:**

**Critical Response:**

**Reaction Symptoms/Signs:**

**Procedure:**

**Additional Information:**

Date Completed: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewer Signature: \_\_\_\_\_ Date: \_\_\_\_\_