



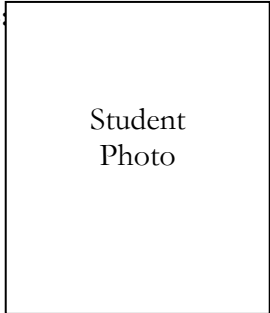
Emergency Care Plan

TRANSPLANT RECIPIENTS

Student: _____ Grade: _____ School Contact: _____ DOB: _____
 Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____
 Father: _____ FHome #: _____ FWork #: _____ FCell #: _____
 Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF IMMEDIATE MEDICAL CARE MAY INCLUDE ANY/ALL OF THESE:

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Student Photo

STAFF MEMBERS INSTRUCTED:

- Administration Classroom Teacher(s) Special Area Teacher(s)
 Support Staff Transportation Staff

TREATMENT: _____

Call school nurse. Call parent/guardian if off school grounds.

Preferred Hospital if transported: _____

Transportation Plan: Medication available on bus Medication NOT available on bus Does not ride bus

Special instructions: _____

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

- Copy provided to Parent Copy sent to Healthcare Provider

This plan is in effect for the current school year and summer school as needed.