

- To be completed by child's Doctor

St. Anthony's Secondary School
Longfords, Antigua
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EMERGENCY CARE PLAN

NAME.....

GRADE.....AGE.....DATE OF BIRTH.....

PARENT/CAREGIVER NAME.....

ADDRESS.....

PHONE (h).....(c).....(w).....

DOCTOR.....

PHONE (Office).....(c).....

To provide assistance to a pupil experiencing symptoms related to a health condition.

HEALTH CONDITION:.....

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POSSIBLE WARNING SIGNS AND SYMPTOMS:.....

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.....

CURRENT TREATMENT, MEDICATIONS AND POSSIBLE SIDE EFFECTS:

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.....

.....

OTHER:.....

.....

ACTION TO TAKE:.....

.....

.....

.....

.....

CALL 911 (IF):.....

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I authorize school personnel/nurse/doctor to implement this Emergency Care Plan as describe above.

.....
Doctor

.....
Date

I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give consent for school authorities to communicate with the authorized doctor when necessary.

My child does not need services

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Parent

.....
Date