Archway Programs
Just Kids

HEALTH EMERGENCY PLAN

Students With Special Health Care Needs

Student: _____ Date:_____
Birth date: _____ School: _____
Preferred hospital in case of emergency: _____
Physician: _____ Phone #: _____
Condition requiring plan: _____

STUDENT-SPECIFIC EMERGENCIES

If You See This- specific symptoms/reactions	Do This
1	
2	
3	
4	
5	
6	

Emergency Contact Person: Name/ relation to child	Phone Numbers

_____ _____
Signature of Health Care Provider Date