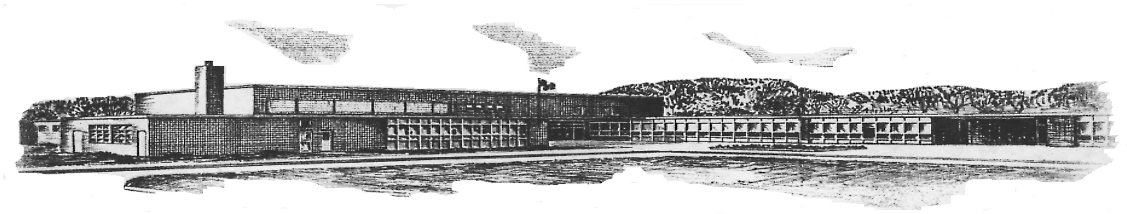

HAMILTON CENTRAL SCHOOL

Individualized Emergency Care Plan

To be completed by the parent or guardian: (Please Print All Information)

Name of Student: _____ Sex: _____ Date of Birth: _____

Address: _____

Mother/Guardian: _____ Ph: _____

Father/Guardian: _____ Ph: _____

Primary Physician: _____ Ph: _____

Hospital of choice: _____ Ph: _____

Other Physician: _____ Ph: _____

Allergies (please list)

- _____
- _____
- _____

Please describe the condition for which this emergency plan is needed (name, symptoms etc...):

_____

_____

_____

_____

Please describe the Emergency Plan (steps) you would like Hamilton CSD to take (e.g. type of medical care, who to call first, who to call 2nd if no answer etc…)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Parent/Guardian Signature: _____

School Nurse Signature: _____

47. W. Kendrick Ave
Hamilton, NY 13346
P: 315-824-6300 F: 315-824-6334