



STUDENT EMERGENCY PROCEDURE PLAN (S.E.P.P.)

Student's Name: _____ Date of Birth: _____	School: _____ Teacher: _____ Grade: _____
Parent/Guardian: _____ Ph-H: _____ Address: _____ Ph-W: _____ _____ Postal C: _____ Parent/Guardian: _____ Ph-H: _____ Address: _____ Ph-W: _____ _____ Postal C: _____ Emergency Contacts: Relationship: _____ _____ Ph-H: _____ Ph-W: _____ _____ Ph-H: _____ Ph-W: _____ Doctor: _____ Ph: _____ Address: _____ Postal C: _____	Place Student's Photograph Here
Name of medical condition(s): _____ _____ Describe: _____ _____ _____ What symptoms might your child experience while at school? _____ _____ _____ What symptoms may require emergency care _____ _____ _____ If these symptoms occur, what care do you want your child to receive? _____ _____ _____ The Designated First Aider will be called and 911 may be activated for ambulance. If your child requires medications while at school, you will have to complete a Medication Administration form (available at the school). Name of Medication(s): _____ _____ _____ Does your child wear a Medic Alert bracelet? _____	

RETURN FORM TO SCHOOL AND DISCUSS WITH ALL YOUR CHILD'S TEACHERS.

Parent/Legal Guardian Signature _____ Date: _____