

Life-Threatening Condition Emergency Care Plan (ECP)

Student Information			
Senior Name:		Emergency Contact 1 (Full Name & Phone #):	
School:		Emergency Contact 2 (Full Name & Phone #):	
DOB:	Night-of-Event Bus: <i>Onsite help to enter day of event</i>		
Please list all life-threatening conditions:		Will the senior be bringing any of the following onsite?	Who will carry? <i>(Senior or Chaperone)</i>
<input type="checkbox"/> Allergy (Please specify): _____		<input type="checkbox"/> Allergy Medication (Please specify): _____	_____
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epi Pen (__ .3mg) (__ .15mg)	_____
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Inhaler	_____
<input type="checkbox"/> Cardiac Issues		<input type="checkbox"/> Insulin / Glucose Monitor	_____
<input type="checkbox"/> Seizures		<input type="checkbox"/> Other Medications (Please specify):	_____
<input type="checkbox"/> Other (Please specify): _____		_____	_____
Will the senior be bringing separate food to the event? <input type="checkbox"/> YES <input type="checkbox"/> NO			
(Allergy) Senior to should avoid contact with these allergens: (Asthma) Senior to avoid contact with these Asthma triggers: (Seizures) Senior to avoid contact with these seizure triggers: Please list side effects of any carried medication:			
<i>In the spaces below, please detail your Action Plan for each applicable life-threatening condition. Make sure to include who to contact and their contact details, if applicable.</i>			
Immediate Response Plan			
Applicable life-threatening condition: _____			
Detail here:			
<i>Please use the back of this sheet for additional space if needed</i>		More details on the other side? <input type="checkbox"/> Yes	
I agree to notify the Planning Committee of any changes to the information on this form between now and the date of graduation.		By: _____ (Parent/Guardian's Signature) Date: _____	

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