2025 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: *Onsite help to enter day of event*	

Authorization for Use or Disclosure of Protected Health Information
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.

I, _____, hereby authorize employees of the school listed on this form and their volunteers, Grad Nights Staff and their volunteers, and any relevant Healthcare Providers to disclose and release my child's protected health information provided on this form. This release is only valid in the event of medical need or emergency from date of signature. I agree to notify the Planning Committee of any changes to the information on this form between now and the date of graduation.

_____ _____
Signature of the Individual Giving this Authorization Date

Please list all life-threatening conditions:	Will the senior be bringing any of the following onsite?	Who will carry? *(Senior or Chaperone)*
□ Allergy (Please specify): _____	□ Allergy Medication (Please specify): _____	
□ Asthma	□ Epi Pen (__ .3mg) (__ .15mg)	
□ Diabetes	□ Inhaler	
□ Cardiac Issues	□ Insulin / Glucose Monitor	
□ Seizures	□ Other Medications (Please specify): _____	
□ Other (Please specify): _____	_____	

Will the senior be bringing separate food to the event? □ YES □ 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:

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.

Immediate Response Plan

Applicable life-threatening condition(s):_____
Detail here:

Please use the back of this sheet for additional space if needed | **More details on the other side?** □ **Yes**

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