

2023 Emergency Care Plan (ECP)

| Student Information | | |
|---|---|---|
| Senior Name: | Emergency Contact 1 (Full Name & Phone #): | |
| School: | Emergency Contact 2 (Full Name & Phone #): | |
| Student ID: | | |
| DOB: | Night-of-Event Bus: <small><i>Onsite help to enter day of event</i></small> | |
| <p>Authorization for Use or Disclosure of Protected Health Information Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.</p> <p>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 through July 1st, 2023. I agree to notify the Planning Committee of any changes to the information on this form between now and the date of graduation.</p> | | |
| _____ Signature of the Individual Giving this Authorization | _____ Date | |
| Please list all life-threatening conditions: <input type="checkbox"/> Allergy (Please specify): _____ <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Cardiac Issues <input type="checkbox"/> Seizures <input type="checkbox"/> Other (Please specify): _____ | Will the senior be bringing any of the following onsite? <input type="checkbox"/> Allergy Medication (Please specify): _____ <input type="checkbox"/> Epi Pen (__ .3mg) (__ .15mg) <input type="checkbox"/> Inhaler <input type="checkbox"/> Insulin / Glucose Monitor <input type="checkbox"/> Other Medications (Please specify): _____ _____ _____ | Who will carry? <i>(Senior or Chaperone)</i> _____ _____ _____ _____ _____ |
| 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(s): _____ 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 | |

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