UNIONTOWN AREA SCHOOL DISTRICT
EMERGENCY HEALTH CARE PLAN

Name:	
Regular HCP ☐ 504 HCP ☐	Date:
School:	Grade:
Student Number:	Birth Date:
Health Concerns/Diagnosis:	

Allergies:	
Medications:	**Dose/Time:**
Emotional/behavioral concerns:	
Dietary concerns/restrictions:	
Health Action Plan:	

Parent Signature	**Date:**
M.D. Signature (or med. Authorization form)	**Date:**

More information on other side →	
Contact Information:	
Parent/Guardian: 1. _____ 2 _____	**Home phone:** **Work:** _____ **Cell:** _____ **Work:** _____ **Cell:** _____
Home Address:	**Teacher:**
Emergency contact:	**Phone:**
Primary Care Physician:	**Phone:**
Speciality MD:	**Phone:**
School Nurse:	**Phone:**

Copies:

- ☐ Parent
- ☐ Teacher 1st___ 2nd___ 3rd___4th___ 5th___ 6th____ 7th___
- ☐ PE
- ☐ Library
- ☐ Music
- ☐ Recess
- ☐ Transportation
- ☐ Health Care Plan Book Master
- ☐ Clinic