

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: <small><i>Onsite help to enter day of event</i></small>	
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:		
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: _____ Detail here: 		
Please use the back of this sheet for additional space if needed		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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