

Emergency Action Plan (EAP)

Emergency Action Plan

Name _____ D.O.B. _____
Address _____ Homephone _____
Parents/guardians _____ Grade _____
School _____
Healthcare provider(s) _____
Insurance provider _____ ICD-10-CM _____
IEP Date _____ 504 Date _____ EAP Date _____ EEP Date _____

Medical Diagnosis:

If You See This:

Do This:

Other:

Initiated by School Nurse _____ Signature _____ Date _____