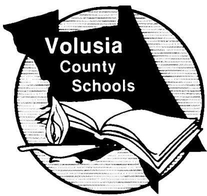

DeLand (386) 734-7190 | Daytona Beach (386) 255-6475 | New Smyrna Beach (386) 427-5223 | Osteen (407) 860-3322

EMERGENCY CARE PLAN

Student: ____ Date: ____________

DOB: _____________ School: __________________________________ Grade: ______

Reason for Plan: ________________________ Allergies: ____________________________

This authorization is valid for this school year only unless earlier date is specified:__________

POSSIBLE EMERGENCY SITUATIONS:

IF YOU SEE THIS:	DO THIS:

If any of the above conditions are observed:
1. An adult is to stay with the student.
2. Notify the nurse: student's name, location of student, the problem.
3. The school nurse will assess the student and situation and decide on management.
4. If treatment interventions are not successful 911 will be called.
5. If there is no school nurse available, the following are to be notified to determine management:

Emergency Information:

Student's Home Address: ______________________________Phone: ___________________
Mother: ______________________________Work#: _______________ Home#: __________
Father: ______________________________Work#: _______________ Home#: __________
Other Contact: __________________________Work#: _______________ Home#: __________
Preferred Hospital: ____Phone:_______________
Local Hospital Emergency Room: ______________________________Phone:_______________
Primary Physician: ____Phone:_______________
Specialists: ____ Phone:_______________
____Phone:_______________

AUTHORIZATION:

☐ Yes ☐ No I give permission for the physician and school district personnel to exchange pertinent information pertaining to this child's condition/progress.

_________________________________ _________________________________
Parent/Guardian Date | Physician Signature Date

_________________________________ _________________________________
Administrator Date | Nursing Supervisor Signature Date

Emergency Care Plan should be revised according to student's specific needs.

Emergency Care plan forwarded to Transportation, Date: __________________