

Craven County Schools

Health Program

EMERGENCY PLAN FOR STUDENTS WITH SPECIAL HEALTH NEEDS

Student: _____ Date of Birth: _____

School: _____ Teacher: _____

Medical Diagnosis/Condition: _____

Symptoms/Signs/Events which indicate a need to activate Emergency Plan: _____

Steps to be followed (number in order to be done): _____

I have read and approve this Emergency Plan.

Physician's Signature _____ **Date**

Physician's Signature _____ **Date**

*Emergency names and phone numbers are listed on the back.

The following people have been trained to deal with this emergency:

Person developing Emergency Plan: _____

1 Parent/Guardian: _____

Relationship to Child: _____

Home
Address: _____

Work
Address: _____

Home Phone: _____ Work
Phone: _____

2 Parent/Guardian: _____

Relationship to
Child: _____

Home
Address: _____

Home Phone: _____ Work
Phone: _____

3 Other Contact Person: _____

Relationship to Child: _____

Home Address: _____

Work Address: _____

Home Phone: _____ Work Phone: _____

4 Other Contact Person: _____

Relationship to Child: _____

Home Address: _____

Work Address: _____

Home Phone: _____ Work Phone: _____

Physician to be called first: _____

Preferred Hospital: _____

Address: _____ Phone: _____

Preferred Hospital: _____

Emergency Room Phone Number: _____

Rescue Squad Phone Number: _____