EMERGENCY CARE PLAN

Learner Name____ **Date of birth**___/___/_____

Allergies________________________ **School**__________________ **Grade / Teacher**__________________

MEDICAL CONDITION (Check all that apply)

☐ Asthma: Triggers: ____

☐ Allergies: ____ **Food Allergies (**complete form FCAA-E1**)

Anaphylaxis: Yes No / Class: 1 2 3 4 5 6 / Exposure: Inhaled Ingestion Contact

☐ Seizure (circle type): Absence / Generalized Tonic Clonic / Simple Partial / Complex Partial / Febrile
(Staff use form ACBD-E9 for recording instances)

☐ Other: ____

TO BE COMPLETED BY THE HEALTHCARE PROVIDER

Symptoms that may occur ____.

Emergency Treatment ____.

Restrictions(activity/temp) ____

Procedures **(complete form ACBD-E5)** or other details school staff should be aware of:____.

Does this learner take preventative medication at home? Yes No
If yes, list medication(s) ____.

Does this learner require medication at school? Yes No
If yes, list medication(s) (**complete form ACBD-E2**) ____.

Provider Name____ **Location**____________________

Phone___________________________________ **Fax**____________________________________

Provider Signature X____ **Date**________________

Emergency Medical Services (911) & First Aid may be activated if…

- Emergency Medication is administered.
- Unresponsive or unusually confused.
- Bleeding that will not stop.
- Head or neck injury is severe.
- Anaphylaxis or multisystem reaction to an allergen.
- Respiratory distress / blocked airway or CPR initiated.
- Seizures lasting longer than 5mins (unless otherwise stated).
- Inability to be moved.

I authorize the school nurse or designated personnel to contact the prescriber as needed to obtain or clarify health information and share information outlined in this “Emergency Care Plan” with individuals working within the school who need to know for the purpose of providing first aid or other specific emergency care as described in this plan. I approve and request school personnel to follow the above plan in an emergency involving my child. I agree to notify the school immediately if my child's health status changes, or there is a change or cancellation of this “Emergency Care Plan.” I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the learner's health record.

Furthermore, by signing I understand I can revoke this authorization at any time in writing and agree to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the administration of cars and/or treatments to the above-named learner from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney’s fees, caused, or claimed to be caused or to result from care in accord with the above ”Emergency Care Plan”.

Parent/Guardian Name____

Phone: (H)____________________ **(C)**_____________________ **(W)**_____________________

Alternate Contact Name____

Phone: (H)____________________ **(C)**_____________________ **(W)**_____________________

Parent /Guardian Signature X____________________________________ **Date**______________