EMERGENCY CARE PLAN

Student Information				Photo (Optional)
Student:		**DOB:**		
School:		**Grade:**		

Medical Condition(s) Requiring Emergency Planning:
Allergies:

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

Possible Emergency Situations:	
If You See This:	**Do This:**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

If any of the above conditions are observed:

1. An adult is to stay with the student.
2. Notify the clinic staff: student's name, location of student, the situation.
3. The clinic staff will assess the student and situation and decide on management.
4. ⚠ **Call 911 immediately if treatment measures are unsuccessful or as directed in the care plan.**
5. If there is no clinic staff available, the following are to be notified to determine management:

Emergency Contact Information:			
Student's Home Address:		Phone No:	

Parent/Guardian 1:		Relationship:	
Phone No.:		Alternate Phone No. :	
Parent/Guardian 2:		Relationship:	
Phone No.:		Alternate Phone No. :	
Emergency Contact:		Relationship:	
Phone No.:		Alternate Phone No. :	

Preferred Hospital:		Phone No.:	
Local Hospital Emergency Room:		Phone No.:	
Primary Physician:		Phone No.:	
Specialists:		Phone No.:	

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

Provider Signature Date

School Administrator Date

RN Supervisor Signature Date

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

School Personnel Use Only

Emergency Care Plan forwarded to Transportation Department via on: _____

☐ Secure e-mail ☐ Interoffice Mail ☐ Other: _____

Clinic Staff Printed Name, Initials and Date:_____