STUDENTS with SPECIAL HEALTH CARE NEEDS
EMERGENCY ACTION PLAN

ATTACH PHOTO HERE

Date:_________
Student's Name:_________________DOB:______Grade:___Teacher:____________
Special Health Care Need/Diagnosis:________________________________
____
Physician: ______________________________Phone:_________________
Preferred hospital in case of emergency:_______________________________________

STUDENT-SPECIFIC EMERGENCIES

IF YOU SEE THIS	DO THIS

IF AN EMERGENCY OCCURS:

1) If life threatening, immediately call 9-1-1.
2) Stay with the student or designate another adult to do so.
3) Call or designate someone to call the school nurse and/or principal.
4) Call parents or emergency contacts listed:

MOTHER:_________________#:____________________CELL#_________________
FATHER:__________________#:____________________CELL#:_________________
EMERGENCY CONTACT:_________________________RELATION:_____________
PHONE:_____________________CELL_________________
EMERGENCY CONTACT:_________________________RELATION:_____________
PHONE:_____________________CELL:________________
DOCTOR:__________________________PHONE______________________________

TRAINED STAFF MEMBERS:

1. ______________________________________ROOM/PHONE:_______________
2. ______________________________________ROOM/PHONE:_______________
3. ______________________________________ROOM/PHONE:_______________

PARENT SIGNATURE:_________________________DATE:_________________

DOCTOR'S SIGNATURE:_______________________DATE:_________________