Immaculate Conception High School

EMERGENCY PLAN

FOR STUDENTS WITH SPECIAL HEALTH CARE NEEDS

Including but not limited to: Seizure disorder, Sickle Cell Disease, Blood Diseases, Diabetes.

Name:_____Medical Diagnosis:_____

Birthdate:_____Grade:_____Bus:____Yes____No -- Bus Name:_____

Parent/Caregiver Name:_____

Home and Emergency Phone #'s:_____

Physician:_____Telephone #:_____

Preferred Hospital in case of emergency:_____

STUDENT SPECIFIC EMERGENCY CARE PLAN:

IF YOU SEE THIS	DO THIS
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IF AN EMERGENCY OCCURS:

1. If the emergency is life threatening, do not hesitate to immediately call **911.**
2. Call or designate someone to call the nurse and the principal. State whom you are and where you are and the problem you see.
3. ALWAYS STAY WITH STUDENT OR DESIGNATE ANOTHER ADULT TO DO SO.

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To insure your child's safety at school, this medical information may need to be shared with school staff members on a need to know basis. By signing below you acknowledge that the school nurse may share the medical information noted above.

_____ _____

Parent/Caregiver Signature/Date Physician's Signature/Date