Charlotte-Mecklenburg Schools

Mecklenburg County Health Dept

SCHOOL HEALTH SERVICES
A Partnership for Serving Children

EMERGENCY ACTION PLAN

Name: _____

School: _____Year: _____ Grade: _____ Date of Birth: _____ Allergies:_____

Homeroom Teacher: _____ Room: _____ Student ID #:_____

Parent/Guardian: _____ Ph. (H): _____

Address: _____ Ph. (W): _____

Parent/Guardian: _____ Ph. (H): _____

Address: _____ Ph. (W): _____

Emergency Phone Contact #1: _____ _____ _____

Name Relationship Phone

Emergency Phone Contact #2: _____ _____ _____

Name Relationship Phone

Physician treating student for condition: _____ Phone: _____

Other Physician: _____ Phone: _____

Preferred Hospital: _____

EMERGENCY PLAN

Medical Diagnosis: _____

Emergency action is necessary when the student has the following signs:

_____

Steps to take if any of the above listed signs occur:

STUDENT – SPECIFIC EMERGENCY PLAN

IF YOU SEE THIS:	DO THIS:

If student requires 911 services, transport to _____Hospital and contact parents/guardian.

DAILY MANAGEMENT PLAN:

Student's medical diagnosis: _____

1. What medication is taken daily?

   Name: _____ Dosage: _____ Time of Day: _____

   Name: _____ Dosage: _____ Time of Day: _____

2. Has your child ever been hospitalized for this medical condition? Yes _____ No _____ If so, when? _____

3. Are there activities or stressors that increase the incidence? _____

4. List the activities in which your child can not participate: _____

*** PLEASE NOTE: If medications are to be taken at school, a Medication Authorization form must be completed by the parent and physician and kept at the school.**

This information will be shared with appropriate school staff unless you state otherwise.

_____ _____

Parent/guardian Signature Date

_____ _____

School Nurse Signature Date