**Sample Emergency Care Plan for Unlicensed School Personnel**

This sample plan should be customized for each individual student

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| **Student Information** | | | | |
| Name: | | | | Date Plan Developed |
| School Contact Phone: | | | | DOB |
| Teacher/HR: | | | | Grade 🞎 N/A |
| Medical Conditions: Medications: | | | | |
| **Emergency Contact Information** | | | | |
| **Name** | **Relationship** | | **Phone** | |
| Name | 🞎 Parent/Guardian   🞎 Other- List relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🗸 if cell phone 🞎 | |
| Name | 🞎 Parent/Guardian   🞎 Other- List relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🗸 if cell phone 🞎 | |
| Name | 🞎 Parent/Guardian   🞎 Other- List relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🗸 if cell phone 🞎 | |
| **If Student Complains or You See This** (Customize this section for the student) | | **Take These Actions** (Customize this section for the student) | | **🗷 Completed Time** |
| States feels “scared, something bad is going to happen” and has additional symptoms below:  Itching and swelling of the lips, tongue, or mouth  Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough  Hives, itchy rash all over their body  Nausea, stomach cramps, vomiting, and/or diarrhea  Trouble breathing such as shortness of breath, repetitive coughing, and or wheezing  Suddenly not able to speak, see, walk, or move  Suddenly weak or drooping on one side of the body  Signs of shock, passing out, unresponsive | | Notify Nurse if Available at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assist student to take prescribed medication if available   * If severe allergy (anaphylaxis) is suspected lie down and elevate feet * If the student has a known diagnosis of asthma and is having trouble breathing, keep them in sitting position- do not lie down   Call 911 or EMS for Transport  Begin CPR/Rescue Breathing  Notify Administration and Parents | | 🞎 \_\_\_\_\_\_  🞎 \_\_\_\_\_\_  🞎 \_\_\_\_\_\_    🞎 \_\_\_\_\_\_  🞎 \_\_\_\_\_\_  🞎 \_\_\_\_\_\_ |

**This plan was developed by the School Nurse (RN) below and reviewed with staff members**

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| --- | --- |
| School Nurse Name: | Date: |
| School Nurse Signature: | Copy to Parent (Optional) 🞎 |
| School Nurse Phone Contact: | |