



LACORDAIRE ACADEMY

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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: _____

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 who you are and where you are and the problem you see.
3. ALWAYS STAY WITH STUDENT OR DESIGNATE ANOTHER ADULT TO DO SO.

To ensure 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