Tri-County Community Council, Inc.
Head Start

SPECIAL HEALTH NEEDS EMERGENCY PLAN

Diagnosis:_____ **Center:**_____

Child's Name:_____ Date:_____

Allergies:_____ Birth Date:_____

Parent/Guardian:_____ Phone:_____

Emergency Contact:_____ Phone:_____

Health Care Provider:_____

Medications:_____

CLASSROOM
Location of Medication:

CHILD – SPECIFIC EMERGENCIES:

If you see a child **EXHIBITING**	**DO THIS**
•	➢
•	➢

IF AN EMERGENCY OCCURS:

1. If the emergency is life threatening, immediately call 911.
2. Stay with the child or designate another adult to do so.
3. Call, or designate someone to call, the Parent/Emergency Contact and the Head Start Director, _____, at _____.

Comments:_____

Health Services Coordinator Signature:_____ Date:_____

Parent/Guardian: Do you give permission to post this emergency plan in the classroom? _____Yes_____No

Parent/Guardian's Signature:_____ Date:_____