**STUDENTS WITH SPECIAL HEALTH CARE NEEDS
EMERGENCY PLAN NON-MEDICAL STAFF**

**Student Name: DOB: ­­­­­­­­­ Teacher: RM/Grade:**

**Parent/Guardian : Preferred Hospital:**

**Home Phone#: Work#: Cell#:**

**Emergency Contact: Phone:**

***IF YOU SEE THIS* *DO THIS***

**DOCUMENTATION OF STAFF TRAINING**

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| **DATE:** | **TRAINED BY:** | **STAFF NAME:** |
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