A black circle with a star and a flame

Description automatically generated

Place Student’s Picture Here

Elementary School

# CONFIDENTIAL

## Individual Emergency Safety Plan

Name of Student: Click or tap here to enter text. School: Click or tap here to enter text. Grade: Choose an item. Site Special Needs Safety Coordinator: Click or tap here to enter text. Site Principal: Click or tap here to enter text.

Completed by: Click or tap here to enter text. Date completed: Click or tap to enter a date.

Responsible Party for Plan Updates (include role): Click or tap here to enter text.

Please check the box next to the condition that identifies the student’s need for evacuation assistance. Check all boxes that apply:

1. **Communication or Speech-Related Disability:**  **Non-verbal**  **Non-English speaking**  **Uses sign language**

**Assistive technology device used:** Click or tap here to enter text.

1. **The student is mobility impaired and uses:**

Wheelchair  Walker  Body Brace  Other: Click or tap here to enter text.

1. **The student has a vision/hearing impairment:**

Legally blind (Do not check box when the sight is resolved by wearing corrective lenses)  Hearing impaired

**Assistive device used:** Click or tap here to enter text.

1. **The student has the following condition(s):**

Autism  Seizure  Intellectual Disability  Severe Allergy  Asthma  Diabetes

Emotional/Psychological Disorder: Click or tap here to enter text.

Other Health Condition: Click or tap here to enter text.

Medication(s) Taken:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **Time(s)** | **Taken at Home/School** | **Cannot Miss Dose** |
|  |  |  | Home  School |  |
|  |  |  | Home  School |  |
|  |  |  | Home  School |  |
|  |  |  | Home  School |  |
|  |  |  | Home  School |  |

Medication Storage Location (if applicable):  Health office  Classroom  Other: Click or tap here to enter text.

Other Equipment required (if applicable): Click or tap here to enter text.

Type of Evacuation Equipment (if applicable): Click or tap here to enter text.

Location of Evacuation Equipment (if applicable): Click or tap here to enter text.

Special Instructions: Click or tap here to enter text.

Additional Needs (e.g., comfort items, health and hygiene, seasonal needs)

|  |  |
| --- | --- |
| Area of Need | Item(s) |
|  |  |
|  |  |
|  |  |

This plan will be revised as necessary to address the student’s schedule changes.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Time of Day** | **Room #** | **Teacher** | **Assigned Personnel for Evacuation**  **Primary Alternate** | |
| Before School Program |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| After School Program |  |  |  |  |

**I acknowledge, with my signature below, that the information on this plan concerning my child is accurate and have been provided the opportunity to discuss with district personnel any concerns that I may have concerning the safety of my child in the event of an emergency. I also permit the release of this document to any and all persons assisting during an emergency, including district staff, volunteers, and emergency responders. I understand that I have the right to revoke this authorization, in writing, at any time.**

**PRINT Parent Name:**  **Parent Signature:**

**Date:**

**Important Note: Use of this form should be approved by district senior leadership and district legal counsel.**