



Student Emergency Transport Guidelines

A student may be transported without parental permission in an emergency arising from an illness or injury to said student.



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TRANSPORT OF A STUDENT IN AN EMERGENCY

BACKGROUND

A student may be transported without parental permission in an emergency arising from an illness or injury to said student.

Education Code Section 35350 provides that “No governing board of a school district shall require any student or pupil to be transported for any purpose or for any reason without the written permission of the parent or guardian. This section shall not apply to the transportation of a student in an emergency arising from illness or injury to the student or pupil.”

Except when a written objection to medical treatment (other than first aid) has been previously filed by a parent or guardian, a District is not liable for reasonable medical treatment, even without parental consent when the parent cannot be reached, when a student is ill or injured during regular school hours,

Education Code Section 49407 provides that “Notwithstanding any provision of any law, no school district, officer of any school district, school principal, physician, or hospital treating any child enrolled in any school in any district shall be held liable for the reasonable treatment without the consent of a parent or guardian of the child when the child is ill or injured during regular school hours, requires reasonable medical treatment, and the parent or guardian cannot be reached, unless the parent or guardian has previously filed with the school district a written objection to any medical treatment other than first aid.”

Good Samaritans are not liable when rendering emergency care at the scene of an emergency in good faith.

Business and Professions Code Section 1799.102 provides that “No person who in good faith, and not for compensation renders emergency care at the scene of an emergency shall be liable for any civil damages resulting from any act or omission. The scene of emergency shall not include emergency departments and other places where medical care is usually offered.”

INTRODUCTION

The transport of a student in an emergency involves careful consideration of several, important questions as follows:

- What constitutes an ***emergency*** severe enough to require transport for medical treatment?
- When is ***parental permission*** required to transport a student for emergency medical treatment?
- What are the ***proper procedures*** for transporting a student for emergency medical treatment?
- How can a District ***minimize its liability*** related to transport of students during an emergency?

EMERGENCY PROCEDURES FOR INJURY OR ILLNESS

A medical emergency (emergency) is **a condition** that involves the immediate onset of symptoms, including pain, **severe enough to lead a prudent layperson with an average knowledge of health and medicine to reasonably believe that immediate medical attention is needed** to avoid a serious impairment of bodily functions or serious dysfunction of a bodily organ or part because there is a serious threat to the health of the individual or a fetus. Emergency conditions include suspected heart attack or stroke, sudden or extreme difficulty breathing, sudden loss of consciousness, severe bleeding, severe abdominal pain, and injuries to one or both eyes. When an emergency occurs, proceed as follows:

- **Assess the situation.** Be sure the situation is safe for you to approach. The following dangers will require caution:
 - live electrical wires
 - gas leaks
 - building damage
 - fire or smoke
 - traffic, and/or
 - violence
- A responsible adult should **stay with the student and render first aid** until the person designated to handle emergencies arrives. If the student is transported, a responsible adult should stay with the injured student.
- **Call for help** to the person designated to handle emergencies. In the most convenient method available, contact this person who will take charge of the emergency, render any further first aid needed and call for additional resources as required. If the emergency is life threatening, **call 911** or your local emergency number. The responsible school authority or a designated employee should then **notify the parent or legal guardian** of the emergency as soon as possible to determine the appropriate course of action.
- **DO NOT give medications** unless there has been prior approval by the parent or guardian. Follow school district medication policy.

- **DO NOT move** a severely injured or ill student or staff unless absolutely necessary for immediate safety. If moving is necessary, follow guidelines for “NECK AND BACK INJURIES.”
- **DO NOT send an injured or sick child home** unless there has been prior contact with and approval by the parent or guardian. Under no circumstances should a sick or injured student be sent home without the knowledge and permission of the parent or legal guardian.
- **If the parent or legal guardian cannot be reached, notify a parent or legal guardian substitute and call either the physician or the hospital designated** on the STUDENT EMERGENCY/ MEDICAL INFORMATION CARD, so they will know to expect the injured student. If necessary, arrange for transportation of the injured student by Emergency Medical Services (EMS).
- **Complete a report for all incidents** requiring above procedures as required by school policy. Document as required by your District and notify appropriate District administrators.

PREVENTING DISEASE TRANSMISSION

By following some basic guidelines, disease transmission when providing first aid can be largely prevented:

- Avoid contact with bodily fluids, such as blood and other potentially infectious materials (OPIM), when possible
- Place barriers, such as disposable gloves or a clean dry cloth, between the victim's bodily fluids and yourself
- Cover any cuts, scrapes, and openings in your skin by wearing protective clothing, such as disposable gloves
- Use breathing barriers, if available, when breathing for a person
- Wash your hands with soap and water immediately before and after giving care, even if you wear gloves
- Do not eat, drink, or touch your mouth, nose, or eyes when giving first aid
- Do not touch objects that may be soiled with blood, mucus, or other bodily substances

Following these guidelines decreases the risk of getting or transmitting diseases. Remember always to give first aid in ways that protect you and the victim from disease transmission. The American Red Cross recommends the use of a breathing barrier when performing CPR or rescue breaths if you have concerns about making direct contact with a victim.

FIRST AID FLIPCHART

As an appendix to these guidelines, a first aid flipchart derived from the San Francisco Unified School District's (that was adapted from information contained from multiple resources) is included. The first aid flipchart is meant to serve as basic "what to do in an emergency" information for school staff without medical/nursing training. It is recommended that staff in positions to provide first aid to students complete an approved first aid and CPR course. In order to perform CPR safely and effectively, skills should be practiced in the presence of a trained instructor. It is not the intent for these flipchart guidelines to supersede or make invalid any laws or rules established by the District or the State of California. Please familiarize yourself with the format and review the "How to Use the Flipchart" section prior to an emergency situation.

EMERGENCIES REQUIRING TRANSPORT OF VICTIMS

An emergency at a school site often precipitates the need for emergency transport of the student to a hospital or other acute medical treatment facility. **How does one determine if the injury is severe enough to require transport? Normally, the decision to transport is made by EMS personnel** after they have arrived at the scene, assessed the incident, and, as appropriate, consulted with other medical personnel. As such, the subjective judgment of the school nurse or principal to call 911 is not determinative with respect to emergency transport, and emergency calls should be made such that they always err on the side of caution.

Decisions about the need for emergency assistance (and transport) can be enhanced by informed judgment. Informed judgment includes a triage of the victim as to the



severity of her or his injuries. Severities of trauma can be divided into three classes. The worst is Category I. Generally, Category I Trauma Patients meet some or all of the following criteria:

- Does not follow commands (Glasgow Coma Scale¹ (GCS) GCS ≤ 5)
- Hypotension (low blood pressure), even single episode where systolic blood pressure (SBP) < 90 in adults or SBP < 70 in children
- Penetrating injury to head, neck, torso, and proximal to elbows/knees
- Chest injuries with respiratory distress
- Two or more femur/ humerus fractures
- Pelvic fractures
- Paralysis, weakness, or sensory deficit from spinal cord injury
- Amputation above wrist/ankle
- A Revised Trauma Score² of 0 to 10

¹ The **Glasgow Coma Scale** (range of 3 to 15) is a subjective scale of trauma severity. (see "The Glasgow Coma Scale: clinical application in Emergency Departments," *Emergency Nurse* 14 (8): 30–5. 2006) follows:

	1	2	3	4	5	6
Eye	Does not open eyes	Opens eyes in response to painful stimuli	Opens eyes in response to voice	Opens eyes spontaneously	N/A	N/A
Verbal	Makes no sounds	Incomprehensible sounds	Utters inappropriate words	Confused, disoriented	Oriented, converses normally	N/A
Motor	Makes no movements	Extension to painful stimuli (decerebrate response)	Abnormal flexion to painful stimuli (decorticate response)	Flexion / Withdrawal to painful stimuli	Localizes painful stimuli	Obeys commands

² Trauma severity can be estimated as **Revised Trauma Scores** by assigning a value between 1 and 4 to the student's **Glasgow coma scale** (GCS), **systolic blood pressure** (SBP), and **respiratory rate** (RR) (with a total trauma severity range of between 0 and 12) as follows (see also Champion HR, Sacco WJ, Carnazzo AJ, Copes W, Fouty WJ (September 1981). "Trauma score". *Crit. Care Med.* 9 (9): 672–6) :

Revised Trauma Scores

Glasgow Coma Scale (GCS)	Systolic blood pressure (SBP)	Respiratory rate (RR)	Value (one for each range)
13-15	>89	10-29	4
9-12	76-89	>29	3
6-8	50-75	6-9	2
4-5	1-49	1-5	1

Category II Trauma Patients meet some or all of the following criteria:

- Death of another occupant in same vehicle
- Auto vs. pedestrian (or bicycle) injury with significant impact
- Pedestrian thrown/run over
- Extrication time > 20 minutes
- Falls > 20 feet
- Ejection from vehicle
- Vehicle rollover
- High-energy crash
- Motorcycle crash with separation of rider from motorcycle
- Rigid, tender abdomen
- Age <5 or > 55 y/o
- Combination of trauma and burns
- Known heart disease, CHF, COPD
- Bleeding disorder or taking coumadin or heparin
- Pregnancy > 20 weeks
- Amputation of fingers with possibility of reattachment
- A Revised Trauma Score of 11

Category III Trauma Patients include all other injuries and have Revised Trauma Scores of 12.

For Category I Trauma Patients, the District should consider **air ambulance transport** if it is available and if it can deliver patient to Trauma Center faster than ground ambulance or if the patient's GCS ≤ 8 and the aircraft ETA to the scene is less than ground transport time.

[Districts should discuss issues of air versus ground transport with their local EMS in advance and develop internal procedures. Usually, EMS organizations make the call



3

0

0

0

vis-à-vis the appropriate mode based on their internal policy and procedures after their initial assessment. Others may modify their call based on input from the District that includes factors such as the school's remoteness from the EMS response, the school's remoteness from the hospital or trauma medical facility, the school's medical or nursing expertise, etc.]

For Category II Trauma Patients, the District should consider air ambulance transport if it is available and if transport by ground ambulance will take greater than 30 minutes.

For Category III Trauma Patients or for patients with traumatic cardiac arrest, ground ambulance transport is probably preferable.

An emergency is differentiated from a disaster with respect to the illness and injury based on the extent of its scope. If the scope of an emergency is such that local emergency response capabilities are overwhelmed and that a triage of the emergency's victims is necessary in order to allocate resources such as the delivery of first aid, the transport of victims, and the hospitalization of victims, then the emergency becomes a disaster.

For a disaster, emergency procedures are often insufficient, and referral to the District's Comprehensive School Safety Plan can provide further guidance. For example, a disaster involving students might require a Pediatric Multi-casualty Triage³ simultaneous with the application of emergency procedures as follows:

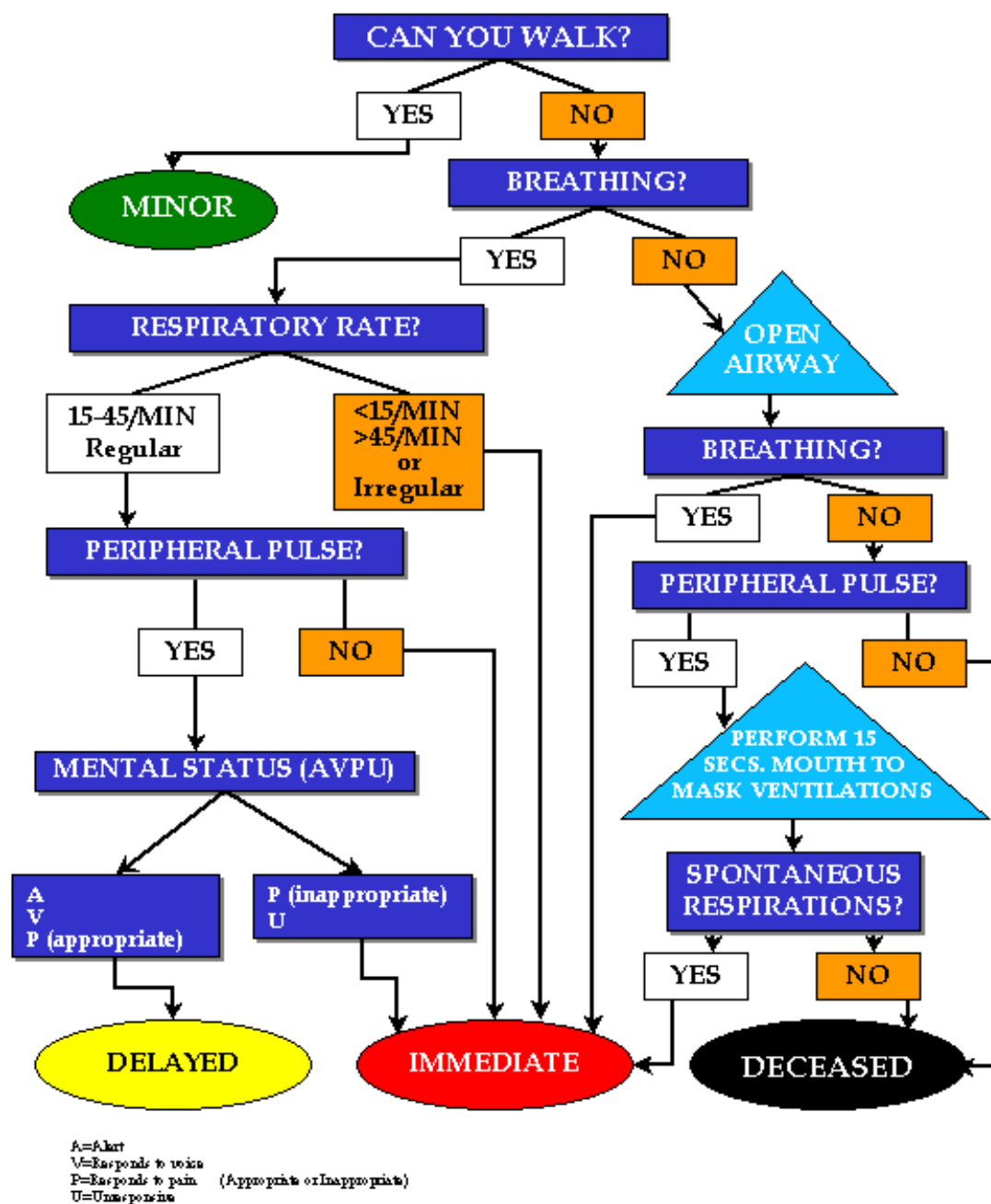
Differences between emergencies and disasters:

1. *Disasters require the response of numerous agencies and organizations and multiple levels of government simultaneously.*
2. *Disasters disrupt the normal autonomy and freedom of action of individuals, organizations, and governmental entities. A new, temporary social order may be put in place during a disaster.*
3. *Different performance and treatment standards apply during disasters. Speed of response and individualized care given to treating the injured is superseded by a need to triage victims to better allocate resources.*
4. *Normal procedures, privacy and property rights, and public/private distinctions may be suspended during disasters. Mobilization supersedes due process for the common good.*

³ See, for example, <http://www.jumpstarttriage.com/>. The topic of these guidelines is transport related to student emergencies. Disasters are the subject of the **Comprehensive School Safety Plan** and related guidelines.

Jump START

Field Pediatric Multicasualty Triage System



TRANSPORT OF STUDENT IN AN EMERGENCY

Procedures When a Parent/Guardian is Present:

- If injured child is in immediate danger, the school nurse or designee will discuss the details with the parent/guardian.
- School nurse will notify administrators/counselors.
- School nurse will call 911.
- Principal will notify Central Administration.
- School nurse will make copies of the student's emergency card: EMT, nurse, principal or designee.
- If the parent/guardian has transportation, the parent/guardian will follow the ambulance to the hospital.
- The principal or designee will follow the ambulance to the hospital and wait for the parent to arrive. The principal or designee will bring a copy of the student's STUDENT EMERGENCY/ MEDICAL INFORMATION CARD^{4, 5}.
- The school nurse will follow up with a phone call later in the day or the next morning.
- Nurse/aide will write an incident report.
- Administrator will call home in the evening. If the administrator is not available, a counselor will call.
- Coaches and teachers should remember to take the students' STUDENT EMERGENCY/ MEDICAL INFORMATION CARDS with them on all outings.
- Coaches and after-school activity proctors will be notified of these procedures.
- All media inquiries will be directed to the District Communications Coordinator or designee.

⁴ Student Emergency/Medical Information Cards should include **written objections to medical treatment (other than first aid)** and **do-not-attempt-resuscitation orders** prominently displayed, if applicable.

⁵ For special needs' students, Emergency Information Forms for Students with Special Needs and 72-Hour Medication Forms should be copied and taken along by the principal or designee, also.

Procedures When a Parent/Guardian Is Not Present:

- If injured child is in immediate danger, the school nurse or designee will attempt to notify the parent/guardian of the situation.
- School nurse will notify administrators/counselors.
- School nurse will call 911.
- Principal will notify Central Administration.
- School nurse will make 3 copies of the student's STUDENT EMERGENCY/ MEDICAL INFORMATION CARD: EMT, school nurse, principal or designee.
- If the child needs to proceed to the hospital, transported by ambulance, the school nurse will communicate the destination (hospital) of the injured child to the parent.
- If the parent/guardian is not available or prefers to meet the ambulance at the hospital, the principal or designee will follow the ambulance to the hospital and wait for the parent to arrive. The principal or designee will bring a copy of the student's emergency card.
- If the parent/guardian is not able to get to the hospital or is unavailable, the school representative will communicate with the nurse to ensure that a listed person on the emergency card has been contacted.
- The school nurse will notify Central Administration on the day the incident takes place.
- The school nurse will do a follow-up communication to the parent on the day of the incident.
- The school nurse will communicate results of the follow-up communication to the principal in writing.
- All media inquiries will be directed to the District Communications Coordinator or designee.
- Administrator will call home in the evening. If the administrator is not available, a counselor will call.
- Coaches and other school staff should remember to take a copy of the student's STUDENT EMERGENCY/ MEDICAL INFORMATION CARD with them when taking students off premises to events and activities.

- Coaches and after-school activity proctors will be notified of these procedures.

Procedures When the School Nurse Is Not Present:

- If the school nurse is out of the building or otherwise not available when an emergency occurs, the secretaries, administrators, guidance counselors, coach, or other trained personnel will handle the situation following the above procedures.

SPECIAL NEEDS STUDENT EMERGENCY PLANNING

For individuals with special needs, conditions are more hostile and difficult to deal with during an emergency. Recognizing this, pre-planning for medical emergencies requires additional considerations. To accomplish this, District teachers and staff responsible for emergency medical care and other emergency programs must:

- Involve the student with special needs, their parents, staff, and teachers in identifying the communication and transportation needs, accommodations, support systems, equipment, services, and supplies that they will need during an emergency,
- Identify medical needs and make appropriate plans,
- Determine transportation needs for students, and
- Include local responders in such planning.

Special Needs Student Planning, Individual Education Programs (IEPs), and Individualized Healthcare Plans (“504” plans)

The Individuals with Disabilities Education Act of 1975 (amended 1997) (IDEA) requires that planning for the educational success of these students is done on an individual case-by-case basis through the development of an Individual Education Program (IEP). Students with special needs who are self-sufficient under normal circumstances may have to rely on others in an emergency. They may require additional assistance during and after an incident in functional areas, including, but not limited to: communication, transportation, supervision, medical care and reestablishing independence. While not explicitly stated, a component of the IEP for related services must consider the particular needs of the child to ensure his or her safety during an emergency. 504 Plans may further address issues relevant to emergencies such as “do-not-attempt-resuscitation orders” (DNR orders⁶).

⁶ California code (Prob. Code 4763 [200]) defines a DNR order as "a written document signed by (1) the individual, or a legally recognized surrogate health care decision maker, and (2) a physician. "Under the law, a specific definition is provided for a "health care provider" however,

Factors that may Elevate and Reduce Risk by Categories of Disability under IDEA Law

Federal Disability Term	Alternative Term	Brief Description/ Factors that Elevate Risk in Emergencies	Factors that Reduce Risk in Emergencies
Autism	Autism spectrum disorder	Characterized by extraordinary difficulty in social responsiveness; often resistant to environmental change or change in daily routine and experience anxiety over interruption. May be non-verbal or use argumentative communication.	Structure, routine, normalcy and familiarity with activity
Deaf-blindness		A simultaneous significant hearing and vision loss; limits the speed of movements.	Guidance from a sighted person
Developmental delay		A delay in one of the following areas: physical development; cognitive development; communication; social or emotional development; or adaptive (behavioral) development.	Minimized disruption of routine patterns of activity, modulate sensory input
Emotional disturbance	Behavior disorder, emotional disability	Has limited ability to understand environmental events, situations, or procedures. Needs are categorized as mild, moderate or severe. May disobey or resist direction, may panic.	Regulated sensory input
Hearing impairment	Deaf, hard of hearing	A complete or partial loss of hearing that adversely affects a child's educational performance. May not respond to auditory cues.	Written instructions, sign language, specialized communication for direction in an emergency
Mental retardation	Intellectual disability, cognitive impairment	Significant limitations in intellectual ability and adaptive behavior. This disability occurs in a range of severity.	Regulated sensory input
Multiple disabilities		The simultaneous presence of two or more impairments, the combination of which causes such severe educational needs that they cannot be accommodated in a special education program solely for one of the impairments. Does not include deaf-blindness	
Orthopedic impairment	Physical disability	A significant physical limitation that impairs complete motor activities, strength, vitality or an alertness to environmental stimuli	Adaptive physical equipment: cane, walker, wheelchair. May require alternative, accessible evacuation route
Other health impairment		A disease or disorder so significant that it negatively affects learning; examples include cancer, sickle-cell anemia, and diabetes	Continuity of medication management regime
Specific learning disability	Learning disability	A disorder related to processing information that leads to difficulties in reading, writing and computing.	
Speech or language	Communication disorder, stuttering	A disorder related to accurately producing or articulating the sounds of language to communicate	Sign language, hand signals, specialized communication for response in an emergency

the statute is silent as to whether or not the definition includes nurses not engaged as emergency response employees. Most school nurses are emergency response employees and would not be expected to comply with a DNR order. A health care provider who honors a request to forgo resuscitative measures shall not be subject to criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction or any other sanction as a result of his or her reliance upon the request, if the health care provider (1) believes in good faith that the action or decision is consistent with this section (Chapter 2, Article 3), and (2) has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under the circumstances."

Federal Disability Term	Alternative Term	Brief Description/ Factors that Elevate Risk in Emergencies	Factors that Reduce Risk in Emergencies
Traumatic brain injury	TBI	An acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both that may affect cognition, behavior, social skills and speech.	
Visual impairment	Low vision, blindness	A partial or complete loss of vision sounds of language to communicate	Guidance from a sighted person

In addition to students with disabilities specified under IDEA law, the school site administrator or designee must identify individuals needing emergency treatment **who also have** temporary or hidden impairments such as asthma, panic attacks, significant allergies, prior injuries, or heart conditions. Students with such documented medical conditions may not have an IEP or 504 plan in place that would highlight the need for special medical considerations, but disclosure of these impairments is relevant, nevertheless.

Medication Management

Many students with special needs have very individualized medication schedules that cannot be interrupted without serious consequences.

Additional Stressors

Children with special needs are likely to respond to any form of stress following a crisis with more extreme reactions. Allow extra time for them than others to make necessary preparations in an emergency. Some students with special needs will need more time to comprehend the emergency. Consider what are the triggers and cues for these students and anticipate rather than react. Adult supervision may need to be more intense for a while.

Additional Documentation

In addition to STUDENT EMERGENCY/ MEDICAL INFORMATION CARDS, special needs students undergoing emergency treatment and transportation should have their **Emergency Information Form for Students with Special Needs** as well as their **72-Hour Medication Forms**. **[If a parent has executed a DNR order for a special needs student who is suffering from a complex chronic disease, Districts should discuss ethical and legal issues related to compliance with DNRs with respect to emergency treatment for trauma and emergency treatment for worsening chronic conditions. Such discussions should include staff, teachers, parents, the**

community, legal counsel, your ASCIP risk services consultant, and local ethical and moral leadership with a goal of development of policy and procedure related to DNR compliance.]

COMMUNICATING ABOUT EMERGENCIES AND EMERGENCY TRANSPORTATION

Apologies are effective in resolving conflicts and helping prevent litigation. However, Districts (and most other parties) have historically withheld apologies because of their use as evidence of liability. In 2000, as part of an effort to encourage apologies, California passed an “Apology Law,” codified under Evidence Code Section 1160⁷, designed to eliminate this disincentive, by shielding apologies from evidentiary use. As written, this law protects only partial apologies, expressions of benevolence and sympathy (for examples, “I feel bad about what happened to you.” or “I’m sorry that you were injured.”). It excludes full apologies, which express regret, remorse or self-criticism (for examples, “I should have prevented you from getting hurt.” or “If the equipment had been adjusted correctly, you wouldn’t have been injured.”). In order to protect the District’s interests and limit its potential liability, District employees should limit their statements to parents, guardians, and students concerning emergencies and emergency transportation to expressions of sympathy. Any explanations, corrective actions, etc. that are warranted will be conveyed, as appropriate, by the District superintendent or his or her designee.

“I’m really sorry that Ashley fell and was hurt.”

“We all feel terrible that Jose was injured.”

NOT

“The school could have prevented that by”

⁷ Evidence Code Section 1160 states “(a) The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to that person or to the family of that person shall be inadmissible as evidence of an admission of liability in a civil action. A statement of fault, however, which is part of, or in addition to, any of the above shall not be inadmissible pursuant to this section. (b) For purposes of this section: (1) “Accident” means an occurrence resulting in injury or death to one or more persons which is not the result of willful action by a party. (2) “Benevolent gestures” means actions which convey a sense of compassion or commiseration emanating from humane impulses. (3) “Family” means the spouse, parent, grandparent, stepmother, stepfather, child, grandchild, brother, sister, half brother, half sister, adopted children of parent, or spouse’s parents of an injured party.” (Added by Stats. 2000, Ch. 195, Sec. 1. Effective January 1, 2001.)

Communicating about emergencies involves overcoming our feelings of fear, apathy, terror, panic, and denial that often arise from such incidents. It is best to be constructive by expressing feelings of concern, primarily concern about the victim. Strategies that are useful include:

- **Focusing on expressing concern** for victims and on actively helping victims.
- Later, **providing action opportunities for families of victims and victims**, if appropriate. Helping them become engaged, as appropriate, can help prevent or mitigate similar future incidents.