EMERGENCY ACTION PLAN FOR STUDENTS WITH MEDICAL NEEDS

For Use Where Applicable (e.g. Classroom, Lunchroom, Out of School Programs)

Date: _____

Student Name: _____

Teacher Name: _____ Class: _____ Room #: _____

Parent/Guardian Name: _____

Telephone #: _____ Emergency #: _____

Alternate Contact: _____

Name of Doctor: _____

Place student's photo here

(to be provided by parent/guardian)

MEDICAL DIAGNOSIS

This student has: ○ Asthma ○ Epilepsy ○ Diabetes

○ Other: _____

_____

RESTRICTIONS

(List restrictions for this student, if any)

POSSIBLE SYMPTOMS

MEDICATIONS

(Note: If expiry date has passed, medication will not be used. An ambulance will be called).

Note: Medication is kept (where)

continued on next page →

EMERGENCY ACTION PLAN Note: Principals must fill out an O.S.B.I.E. Incident Form any time a student receives medical care.

AUTHORIZATION

Name of Doctor: _____ Signature of Doctor: _____

Date: _____

Name of Parent/Guardian: _____ Signature of Parent/Guardian: _____

Date: _____

Name of Principal: _____ Signature of Principal: _____

Date: _____

Permission to Post (where applicable) ○ Yes ○ No

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