

ADMINISTRATIVE PROCEDURE

EMERGENCY ACTION PLAN FOR STUDENTS WITH MEDICAL NEEDS

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

<p>Date: _____</p> <p>Student Name: _____</p> <p>Teacher Name: _____ Class: _____ Room #: _____</p> <p>Parent/Guardian Name: _____</p> <p>Telephone #: _____ Emergency #: _____</p> <p>Alternate Contact: _____</p> <p>Name of Doctor: _____</p>	<p>Place student's photo here (to be provided by parent/guardian)</p>
--	--

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)

ADMINISTRATIVE PROCEDURE

EMERGENCY ACTION PLAN

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

[Empty box for Emergency Action Plan details]

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