SD35 Emergency Plan

Child's Name: _____ **Grade:** ____ **Div./Homeroom:** ____ **Birthdate (d-m-y):** _____

School/Facility Name: _____ **School Year (yyyy-yyyy):** _____

THIS STUDENT HAS A POTENTIALLY LIFE THREATENING MEDICAL CONDITION

Photo

Medical Condition:

Details: _____

Emergency Medication Information:

Medication Name: _____

Expiry Date: _____ Location: _____

Additional Information: _____

EMERGENCY PLAN

1. _____

2. _____

3. _____

THE STUDENT MAY HAVE THE FOLLOWING SIGNS & SYMPTOMS

EMERGENCY CONTACT INFO:

Name	Relationship	Cell Phone	Other Phone

The undersigned parent/guardian authorizes any adult to administer emergency medication following the instructions outlined above to the above named person in the event of a medical emergency, as described above. This protocol has been recommended by a physician/nurse practitioner. ***The plan will be kept in the student's personal record and will be shared with appropriate school personnel annually to assist in responding in an Emergency. It is the parent/guardian's responsibility to advise the school about any changes to this plan. All information will be protected and used in compliance with the Freedom of Information and Protection of Privacy Act (FIPPA) and the Health Information Act (HIA), where applicable.***

_____ _____ _____ _____

Parent/Guardian Signature: Date (d-m-yyyy): Doctor/NP Signature: Date (d-m-yyyy):