

District School Board of Niagara
ADMINISTRATIVE PROCEDURE

APPENDIX A (AP 3-24)
Page 1 of 2

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)
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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 →

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Page 2 of 2

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

COPY TO OSR