

MEDICAL ACTION/ALERT PLANNING FORM

This form is for students who may require emergency care while at school. The information will be reviewed annually and updated when the student's condition changes.

School _____ Grade _____ Teacher _____

INFORMATION AND PLAN WHILE IN THE CARE OF THE SCHOOL

Student Name _____ Birth Date (YMD) _____

Address _____ Personal Health No. _____

Parent/Guardian _____ Phone (H) _____ Phone (W) _____

Emergency Contact _____ Phone _____

Doctor _____ Phone _____

Medical Alert Condition _____

New Condition Yes No Date Identified _____

Symptoms and frequency of occurrence _____

Medications, amount and times given _____

Medication needed at school: Yes No Type _____

If yes, "Request for Administration of Medication at School" form must be filled out and provided to the school.

Classroom precautions: _____

Emergency Plan (Use back if necessary) _____

Other Comments: _____

Parent's Name

Signature

Date

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