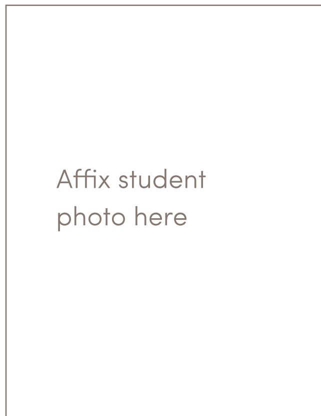
fraser academy

MEDICAL ALERT PLAN
2022-2023

Fill out this form for any medical condition which may require care at the school (e.g. diabetes, epilepsy). For anaphylactic allergies, fill out the **Anaphylaxis Plan** form instead. For asthma, please fill out the **Asthma Plan** form instead. If your child needs medications administered at the school, also fill out the **Administration of Medication** form.

Student Details



Affix student photo here

Student Name	Grade
BC Services Card Personal Health Number (PHN)	Date of Birth (DD/MM/YYYY)
Parent/Guardian 1 Name	Parent/Guardian 1 Phone
Parent/Guardian 2 Name	Parent/Guardian 2 Phone
Alternate Emergency Contact	Phone Number

Indicate what medical condition this student has that may require emergency care at school:

Describe the potential problem (include symptoms that might be observed):

Precautions in the classroom and in the school are:

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MEDICAL CONDITION PLAN
2022-2023

Emergency Plan that school staff members need to follow:

Step 1

Step 2

Step 3

Step 4

Is medication required?

☐ Yes ☐ No

If Yes, please list medication(s):

If Yes, the **Administration of Medication** form must be filled out and provided to the school.

Parent Authorization

I agree with the plan of care outlined in this document. I am aware that the school staff are not medical professionals and will perform all aspects of the plan to the best of their ability and in good faith.

I understand that it is my responsibility to provide an updated plan for each new school year, as well as if my child's condition, medical plan, and/or medication changes. If I wish to cancel this plan, I will do so in writing.

I authorize the school to share this plan and its information with any relevant staff, for the purposes related to the education, health and safety of my child. Information shared will be subject to the school's Privacy Policy.

Signature of Parent/Guardian 1	Parent/Guardian 1 Name	Date (DD/MM/YYYY)

Signature of Parent/Guardian 2	Parent/Guardian 2 Name	Date (DD/MM/YYYY)

Physician Authorization

I have reviewed and am in agreement with this Medical Alert Plan.

Signature of Physician	Physician Name	Date (DD/MM/YYYY)

Physician's Address	Physician's Phone