



Thames Valley District School Board

# Individual Medical Emergency Plan

Student's Name:

Student Photo

Medical Condition:

SYMPTOMS:

NAME/LOCATION/DOSAGE OF MEDICATION:

EMERGENCY PROCEDURES: (INCLUDE ALL TELEPHONE NUMBERS)

ALLERGIES:

This plan was developed on \_\_\_\_\_ and will be reviewed on an annual basis (or earlier) at the request of either the school or parent or Health Professional.

[See page 2]

Signatures:

\_\_\_\_\_  
*Principal*

\_\_\_\_\_  
*Parent(s)/Guardian(s)*

\_\_\_\_\_  
*Health Professional*

**Notice of Collection:** In accordance with Section 29(2) of the Municipal Freedom of Information and Protection of Privacy Act, 1989, this is to advise you that the information you have provided is collected under the legal authority of Section 327 of the Education Act, R.S.O. 1990 c. E2 as amended, and may be used as necessary for some or all of the following principal administrative purposes related to: the Board operation, school programs and educational services, student records, and Ministries of the Government of Ontario. If you have any questions, please contact the Principal and/or the Freedom of Information Coordinator, Thames Valley District School Board, 1250 Dundas Street, London, Ontario, N6A 5L1 (telephone 519-452-2257).

**INDIVIDUAL MEDICAL EMERGENCY PLAN**  
*[Please see outline of plan on the reverse side of this form]*

**MEDICAL CONDITION**

Student Surname: \_\_\_\_\_

Bus Student:  Yes  No

Given Names: \_\_\_\_\_

Bus Route No.: \_\_\_\_\_

Address: \_\_\_\_\_

Bus Driver: \_\_\_\_\_

School: \_\_\_\_\_

Bus Operator: \_\_\_\_\_

School Telephone: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**PARENTS/GUARDIANS**

**EMERGENCY INFORMATION**

	Mother	Father
Name	_____	_____
Home Phone #	_____	_____
Work Phone #	_____	_____
Cell Phone #	_____	_____

Doctor: \_\_\_\_\_

Telephone: \_\_\_\_\_

Hospital: \_\_\_\_\_

Ambulance No.: \_\_\_\_\_

Hospital Emergency No.: \_\_\_\_\_

Fire Department No.: \_\_\_\_\_

Police No.: \_\_\_\_\_

There is a statement from the Doctor in the OSR outlining the nature of the medical condition and any steps to be taken.  Yes  No

**PERSONS INFORMED OF PLAN**

Person	Yes	No	Date Given	By Whom?
<input type="checkbox"/> Parents(s)/Guardian(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
<input type="checkbox"/> ALL School Staff	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
<input type="checkbox"/> Volunteers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
<input type="checkbox"/> Bus Driver(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
<input type="checkbox"/> Bus Operator/Dispatcher	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
<input type="checkbox"/> Emergency Response Personnel [please check appropriate one(s)]				
<input type="checkbox"/> Ambulance	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Police	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Fire Department	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Other (please specify): _____				

**COPIES OF THIS PLAN ARE FILED WITH THE FOLLOWING:**

- Parent(s)/Guardian(s) Date \_\_\_\_\_
- Ontario Student Record Date \_\_\_\_\_
- Bus Operator/Driver Date \_\_\_\_\_
- Principal Date \_\_\_\_\_

**Attachments** (if any): (Please list here and attach)

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