Beautiful Plains SCHOOL DIVISION

MEDICAL RESPONSE PLAN

NAME:_________________________ **GRADE:**__________

TEACHER: _____________________**BUS:**____________

PARENT/GUARDIAN:______________________________

Place student photo here.

TELEPHONE:(home)___________ **(work)**_____________

MEDICAL CONDITIONS:____________________________

SYMPTOMS EXPERIENCED BY STUDENT:__________________________________

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EMERGENCY ACTION TO BE TAKEN:____________________________________

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MEDICATION:______________________________**EXPIRY DATE:**_______________

LOCATION OF MEDICATION:____

FAMILY DOCTOR:__________________________**TELEPHONE:**_________________

OTHER INFORMATION INCLUDING EFFECT OF MEDICATION ON BEHAVIOUR OR CLASSROOM PERFORMANCE____

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I authorize the school to contact the doctor for further information, and I authorize them to release any further information requested by the school.

Date:_______________

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Parent/Guardian Signature

Box 700 Neepawa, MB R0J 1H0 Telephone: (204) 476-2387 Fax (204) 476-3606 Email: bpsd@bpsd.mb.ca