Government of Newfoundland and Labrador
Department of Education

School Medical Plan

Student Information:
Name:_____ Grade: _____School: _____D.O.B.(yr/m/d):_____
Classroom Teacher: _____

Medical Diagnosis or Condition:
_____

Family Contact Information:
Name: _____ Phone # :_____(H) _____(W)_____(C)
Name: _____ Phone # :_____(H) _____(W)_____(C)
If above are not available contact:
Name: _____ Phone # :_____(H)_____(W)_____(C)

Hospital/Clinic Contact Information:
Name: _____ Phone #:_____
Family Physician: _____ Phone #:_____

Daily Medical Needs

Describe	Action/Person Responsible

Emergency Medical Needs (If there is an emergency plan, please attach)

Describe	Action/Person Responsible

Additional Information:

Copied to:

Date completed: _____ May 2008