



Date: _____
(YYYY/MM/DD)

Student Name: _____
(Last Name, First Name, Initial)

Grade: _____

Student
Picture

Description of Significant Health Concern

Identify the health condition / concerns affecting the student

Life Threatening Allergies

Does the student have an epinephrine auto-injector, e.g., EpiPen? ☐ Yes ☐ No

If yes, specify location:

General Precautions / Avoidance

Identify triggers; things to avoid that may bring about a reaction or response

Signs and Symptoms

Describe signs and symptoms of reactions

Emergency Responses

Specify what to do in case of emergency including what medication to administer, who to call and what to do while waiting

Print Name Parent / Guardian / Independent Student

Signature Parent / Guardian / Independent Student

Date (YYYY/MM/DD)

Print Name Principal / Designate

Signature Principal / Designate

Date (YYYY/MM/DD)

Authorization for Collection of Personal Information

Personal information is collected under the authority of the *Education Act* and the *Freedom of Information and Protection of Privacy Act*. This information will be used to respond to the identified medical or physical needs of the student named above. If you have any questions regarding the collection of this information, contact the school principal.