

PRINCE OF WALES SECONDARY SCHOOL 2025-26 EMERGENCY MEDICAL INFORMATION SHEET

Student Last Name:	Grade:
Student Legal First Name:	
Student Usual Called Name:	
Personal Health #:	Student #:
Does your child have any of the followergency care at school? Severe asthma Life-threatening allergy (analysis)	lowing medical conditions which may require Seizure disorder/epilepsy phylaxis) Diabetes
Other:	
None of the above	
Is there anything the school needs t	o know about this condition?
In the event of a medical emergency condition?	y at school, what action is necessary for the above
Prescribed medication(s) for chronic	conditions:
CONTACT INFORMATION:	
Contact Name:	
	Home phone #:
Alternate Contact:	
Cell Phone #:	Home Phone #:
please indicate.	e or supervision to take a medication at school, parent/guardian to provide the school with any require.
Inform the school if the student's en changes during the year	nergency contact information or health condition
	eacher to obtain medical treatment for my son/ ould a need for medical treatment arise the ntact the parent or guardian.
Signature of Parent/Guardian	

PLEASE SIGN AND DATE AND RETURN TO THE SCHOOL OFFICE

The information on this form is collected under the authority of the School Act, Sections 13 and 97. The information will be used for education programs and administrative purposes and, when required, may be provided to health services, social services or other support services as outlined in Section 97 (2) of the School Act. The information will be protected under the Freedom of Information and Protection of Privacy Act. If you have questions about the collection or use of this information, please contact your school principal.