St. Paul's R.C.S.S.D. #20

PHYSICIAN FORM
PROCEDURES FOR PROVIDING EMERGENCY MEDICAL ASSISTANCE AND/OR MEDICATION

Student ______________________________ Date of Birth ____________________

Name of Condition ____

Special Precautions to be Taken

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Action to be Taken in an Emergency

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Medications/Equipment Required

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Qualifications Required to Provide Assistance

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Physician ______________________________

Address ______________________________

Phone ______________________________

______________________________ ______________________________

Physician's Signature Date