

Procedures to deal with a problem: – GENERAL –

1. _____
2. _____
3. _____
4. _____
5. _____

Additional Comments: _____**Medication needed:** YES No **Location at the School:** _____**Medication is Self-Administered:** Yes No

Name of Medication: _____ Expiry Date: _____

Details (Specific side effects, storage, etc.): _____

_____**Training Documentation:**

Name of School	Date of Training/Review	Trainer
_____	_____	_____
_____	_____	_____
_____	_____	_____

- I am aware of Board Policy and Regulation of the Treatment of Students with Medical Problems.
- I agree that the above information is correct.
- If changes occur I will contact the school and provide revised instructions.
- I agree that if medication is required I will supply it to the school in the original container with my child's name and the pharmacist's direction for use, including dosage.
- I am aware that no medication will be administered until this form is completed and returned.
- I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication and that the nurse may contact me as necessary.
- I am aware that staff working with my child my need to know of my child's condition and of the medication required.
- I am aware I am required to update this information each September.

(date)

(Signature of Parent/Guardian)

SCHOOL DISTRICT No. 36 (Surrey)

**MEDICAL ALERT INFORMATION AND CARE PLAN
(General)**

Student Name: _____

Birthdate: _____ Personal Health Number: _____

Date Information Provided: _____

Date when this information was reviewed by Parent/Guardian
(minimum annually):

_____ (date of review)

School emergency contact information:

	Name	Phone Number
Family Doctor	_____	_____
Mother	_____	_____
Father	_____	_____
Alternate Contact	_____	_____
Alternate Contact	_____	_____
Alternate Contact	_____	_____

Medical Condition (Physician diagnosed): _____

Specific Symptoms to watch for:

1. _____
2. _____
3. _____
4. _____
5. _____