SCHOOL DISTRICT No. 36 (Surrey)

MEDICAL ALERT INFORMATION AND CARE PLAN (Allergies)

Student Name: _____

Birthdate: _____ Personal Health Number: _____

Date Information Provided: _____

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

_____ (date of review)	_____ (date of review)	_____ (date of review)
_____ (date of review)	_____ (date of review)	_____ (date of review)

School emergency contact information:

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

Medical Condition (Physician diagnosed): _____

_____

Allergy Description: Food □ Insect Sting □ Other _____

Specific Symptoms to watch for:

1. Flushed face, hives, swelling or itchy lips, tongue, eyes.
2. Tightness of throat, mouth, chest.
3. Difficulty breathing or swallowing, wheezing, coughing, choking.
4. Vomiting, nausea, diarrhea, stomach pains.
5. Dizziness, unsteadiness, sudden fatigue, rapid heartbeat.
6. Loss of consciousness.
7. Other _____

Procedures to deal with a problem: – ALLERGIES –

1. Use EpiPen/Ana-Kit immediately after exposure (do not wait for symptoms).
2. Call an ambulance (even if no symptoms are present) and advise the dispatcher that a child is having a possible anaphylactic reaction and medication has been given (provide details).
3. If an ambulance has not arrived in 10-15 minutes and breathing difficulties are present (e.g. wheeze, cough, throat clearing), give a second EpiPen/Ana-Kit if available.
4. Even if symptoms subside entirely, this child must be taken to hospital immediately.
5. Notify parent.

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 on 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 directions 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 may 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)