

MEDICAL ALERT INFO & CARE PLAN

(Asthma)

To be completed when the school agrees with the parental request to administer medication. To be reviewed at least annually. A new form must be completed if medication changes. This form is to be filed at the school.

A. TO BE COMPLETE	D BY THE PAR	ENT						
Student Name (Last Name, First Name)			D.O.B. (dd/month/year)	Gender 🗖	M 🖬 F Student #		<u>i</u>	
Address		City/ Province	Postal Code		Personal	Personal Health Card #		
Student Home Phone #	MedicAlert [®] I.D.	Teacher		(Grade	Div	Classroom #	
Name of Father			Home Phone # C		Other #			
Name of Mother					Other #			
Name of Guardian					Other #			
Emergency Contact Person			Relationship to Student Phone #					
Alternate Contact Person			Relationship to Student Phone #					
B. ASTHMA INFORMA	TION							
Triggers, symptoms to watch fo	r:							
Special considerations (regarding school activities, sports, trips, physical education etc.):								
C. MEDICATIONS & ADMINISTRATION: to be completed by the attending physician / family doctor For medication which MUST be taken during school hours or during school sponsored events								
News of Mariliantics	(Instructions	re: storage o	of medication for refrigeration	on, etc.)		F	in Data	
Name of Medication:						Exp	iry Date:	
Reason for Medication								
Method of Administration (Dosage, time o	f administration)					Self	Administered Yes DNo	
Additional Instructions								
What is the impact of a missed dose?								
						Pho	ne #	
Name of Physician (please print)		Signature of Pl	hysician	Date				

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D. PROCEDURES TO DEAL WITH A PROBLEM

- 1. Check medications & administration (section C)
- 2. Ensure that bronchodilator medication is available and administered. Have an adult stay with the student.
- 3. Repeat treatment in 10 minutes if symptoms persist.
- 4. The attack is **SEVERE** if:
 - a) Two bronchodilator treatments have not helped, OR
 - b) The student has difficulty speaking, moving; or is turning blue, pale or sweating; or requests a doctor, ambulance or to go to hospital IMMEDIATELY arrange for transportation to hospital CALL 911.
- 5. Notify parent/guardian.

D. TO BE COMPLETED BY THE PARENT / GUARDIAN

Initials

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	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.

to

Date

I am aware I am required to update this information each September, or as it changes.

I authorize and request the administration of the above medicati	on from
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I will provide the medication in the original container with expiration date, labelled by a pharmacist.

Signature of Parent / Guardian E. TO BE COMPLETED BY THE PRINCIPAL OR DESIGNATE

Staff designated to supervise/administer medication

Alternate(s)

Location of Medication in the School

Name of Principal or Designate (please print)	Signature of Principal or Designate	Date	
F. TRAINING DOCUMENTATION			
Date of Training / Review	Name of Trainer		