SCHOOL DISTRICT No. 36 (Surrey)

MEDICAL ALERT INFORMATION AND CARE PLAN (Asthma)

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):*________________________

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Specific Symptoms to watch for:

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________

Procedures to deal with a problem: – ASTHMA –

1. Check medication administration information below.
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 attach is **SEVER**E if:
   a) Two bronchodilator treatments have not helped, **OR**
   b) The student has difficulty speaking, moving; or is blue, pale, or sweating; or requests a doctor, ambulance or to go to hospital.

   IMMEDIATELY arrange for transportation to hospital (phone 911).
5. Notify parent or guardian.

Additional Comments: ____

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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):

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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)