Surrey Schools

**SCHOOL DISTRICT No. 36 (Surrey)**

# FOR LIFE THREATENING CONDITIONS ONLY

**Please circle Medical Condition: Asthma Diabetes Epilepsy Other: _____**

## 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) _____ (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):* _____

_____

**Specific Symptoms to watch for:**

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

*** Parents—Please only complete for Life Threatening Conditions ***

**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)