

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 COMPLETED BY THE PARENT										
Student Name (Last Name, First Name)				D.O.B. (dd/month/year)		Gender ☐ M ☐ F		Student #		
Address				City/ Province			Postal Code		Personal Health Card #	
Student Home Phone #		MedicAlert® I.D. ☐ Yes ☐ No		Teacher				Grade Div		Classroom #
Name of Father				Home Phone #				Other #		
Name of Mother				Home Phone #				Other #		
Name of Guardian				Home Phone #				Other #		
Emergency Contact Person				Relationship to Student				Phone #		
Alternate Contact Person				Relationship to Student				Phone #		
B. ASTHMA INFORMATION										
Triggers, symptoms to watch for:										
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 (Instructions re: storage of medication for refrigeration, etc.)										
Name of Medication:								Expiry Date:		
Reason for Medication										
Method of Administration (Dosage, time of administration)								Self-Administered ☐ Yes ☐ No		
Additional Instructions										
What is the impact of a missed dose?										
Name of Physician (please print)								Signature of Physician		
Date								Phone #		

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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

- _____ 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, or as it changes.

I authorize and request the administration of the above medication from _____ to _____.

I will provide the medication in the original container with expiration date, labelled by a pharmacist.

Signature of Parent / Guardian

Date

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