

MEDICAL ALERT INFO & CARE PLAN

(General)

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	RENT					
Student Name (Last Name, First Name)			D.O.B. (dd/month/year)	Gender □ M □ F		Student #	
Address			City/ Province	Postal Code	Personal	Personal Health Card #	
Student Home Phone #	MedicAlert® I.D. ☐ Yes ☐ No	Teacher		Grade	Div	Classroom #	
Name of Father			Home Phone #		Other #	Other #	
Name of Mother			Home Phone #		Other #	Other #	
Name of Guardian			Home Phone #		Other #	Other #	
Emergency Contact Person			Relationship to Student Phone #		#		
Alternate Contact Person			Relationship to Student Phone #		ŧ		
B. MEDICAL INFORM	ATION (Physic	ian diagr	nosed)				
Diagnosis:			Diagnosed (year)):			
Special considerations (regarding and in the second considerations) C. MEDICATIONS: TO Form	O BE COMPLE	TED BY 1 ST be taken o	THE ATTENDING P	g school sponsored		CTOR	
Name of Medication:	(Instructions	s re: storage	of medication for refrigeration	on, etc.)	Eve	sin, Data	
					EX	oiry Date:	
Reason for Medication							
Method of Administration (Dosage, time of administration)						F-Administered Yes 🔲 No	
Additional Instructions							
What is the impact of a missed dose?							
				_	Pho	ne #	
Name of Physician (please print)		Signature of P	hysician	Date			

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D. TO	BE COMPLETED BY THE PAREN	IT / GUARDIAN				
Initials						
	I am aware of Board Policy and Regulation on the Treatment of Students with Medical Problems.					
	I agree that the information contained within this form is correct.					
	If changes occur I will contact the school and provide revised instructions.					
	 I agree that if medication is required I will suppl for use, including dosage. 	ly it to the school in the original container with my child's na	ame and the pharmacist's directions			
	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 me as necessary. 	school will be informed of my child's condition and medical	ation and that the nurse may contact			
	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.					
Lauthoria	re and request the administration of the abo	ve medication from	to .			
· 		with expiration date, labelled by a pharmacist.				
E TO	Signature of Parent / Gua		Date			
	ated to supervise/administer medication	IFAL OR DESIGNATE				
Stair design	ated to supervisorauminister medication					
Alternate(s)						
Location of	f Medication in the School					
Name of Pri	incipal or Designate (please print)	Signature of Principal or Designate	 Date			
	AINING DOCUMENTATION	- January				
	Date of Training / Review	Name of Trainer				