

MEDICAL ALERT INFO & CARE PLAN (General)

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 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 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