Surrey Schools
LEADERSHIP IN LEARNING

# MEDICAL ALERT INFO & CARE PLAN
(Allergies/Anaphylaxis)

*To be completed when the school agrees with the parental request to administer medication. To be reviewed 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 # | Business # |
| Name of Mother | Home Phone # | Business # |
| Name of Guardian | Home Phone # | Business # |

| **Emergency Contact Person** | Relationship to Student | **Phone #** |
|---|---|---|
| Alternate Contact Person | Relationship to Student | Phone # |

## B. 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)
**If more than 1 medication, please see reverse for more space.**

**Allergy Description:** ❑ Food: Food(s) Allergic to:_____

❑ Insect Sting (specify):_____ ❑ Other: _____

**Symptoms to Watch For:** (Please check)

- ❑ itchy eyes, nose, face, body
- ❑ flushing/redness/warmth of face and body
- ❑ swelling of eyes, face, lips, tongue and throat (throat tightness), trouble swallowing
- ❑ nasal congestion or hay fever-like symptoms (runny itchy nose and watery eyes, sneezing
- ❑ cough, hoarse voice, inability to breathe
- ❑ hives/rash
- ❑ headache, nausea, pain/cramps, vomiting, diarrhoea, uterine cramps in females
- ❑ wheezing, shortness of breath, chest pain/tightness
- ❑ anxiety, a feeling of foreboding, fear, and apprehension
- ❑ weakness and dizziness/light-headedness, pale blue colour, weak pulse, shock
- ❑ loss of consciousness, coma
- ❑ Other_____

**Name of Medication:** **Expiry Date:**
❑ EpiPen® auto-injector ❑ Other:_____

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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## C. Other Medications: 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.)

**Allergy Description:** ❑ Food: Food(s) Allergic to:_____

❑ Insect Sting (specify):_____ ❑ Other: _____

**Symptoms to Watch For:** (Please check)

- ❑ itchy eyes, nose, face, body
- ❑ flushing/redness/warmth of face and body
- ❑ swelling of eyes, face, lips, tongue and throat (throat tightness), trouble swallowing
- ❑ nasal congestion or hay fever-like symptoms (runny itchy nose and watery eyes, sneezing
- ❑ cough, hoarse voice, inability to breathe
- ❑ hives/rash
- ❑ headache, nausea, pain/cramps, vomiting, diarrhoea, uterine cramps in females
- ❑ wheezing, shortness of breath, chest pain/tightness
- ❑ anxiety, a feeling of foreboding, fear, and apprehension
- ❑ weakness and dizziness/light-headedness, pale blue colour, weak pulse, shock
- ❑ loss of consciousness, coma
- ❑ Other_____

**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?

_____ _____ _____ | *Phone #*

*Name of Physician (please print)* *Signature of Physician* *Date*

## D. To be completed by the parent / guardian

Initials

_____ I am aware of Board Policy and Regulation on the Treatment of Students with a Known Risk of Anaphylaxis/Life Threatening Allergies.

_____ 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.

**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*

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# MEDICAL ALERT INFO & CARE PLAN
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## TO BE COMPLETED BY SCHOOL

### E. To be completed by the principal or designate

| |
|---|
| Staff designated to supervise/administer medication |
| Alternate(s) |
| **Location of Medication in the School** |

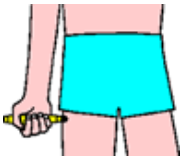
| *Name of Principal or Designate (please print)* | *Signature of Principal or Designate* | *Date* |
|---|---|---|

### F. Training Documentation

| Date of Training / Review | Name of Trainer |
|---|---|
| | |
| | |
| | |

### G. Procedures to deal with a problem: - Allergies / Anaphylaxis

If you see symptoms of a severe allergic reaction or know that a child has eaten something they are allergic to:

1. **Administer the EpiPen®** – Don't hesitate. It can be life saving.
   - i. Pull off grey safety cap 
   - ii. Push black tip into outer thigh
     If necessary may be done through light or single layer of clothing (no thicker than jeans)
   - iii. Listen for a "Click". Hold for 10 seconds. Remove and discard. 
   - iv. **<u>If symptoms persist or recur</u>**, a second dose can be administered in 10 to 20 minutes. *(maximum 3 doses).*
2. **Have someone call 911.** Tell them that a student has had an anaphylactic reaction.
   <u>Give them:</u> Name and address of school (use 911 protocol).
3. The student should rest quietly. DO NOT SEND THE CHILD TO THE OFFICE.
4. Help the student to remain calm and to breathe normally. **An adult must stay with the student.**
5. Call the parents/guardians/emergency contact.
6. Observe and monitor the student until the ambulance arrives.