Surrey Schools
LEADERSHIP IN LEARNING

# 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 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. MEDICAL INFORMATION (Physician diagnosed)

| **Diagnosis:** | **Diagnosed (year):** |
|---|---|

**Describe your child's medical symptoms** *(warning signs, triggers)*:

**Special considerations** *(regarding school activities, sports, trips, physical education etc.)*:

## C. 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.)*

| 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. 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 |
|---|---|
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