SCHOOL DISTRICT #43 (COQUITLAM)

MEDICAL ALERT FORMS

FORM(S) MUST BE COMPLETED AT THE START OF EACH SCHOOL YEAR

Please read instructions below carefully. Feel free to contact your school if you need any clarifications.

This document contains **EIGHT** pages as we have combined all **FOUR** medical forms into one to make it easier for parents to find them and fill them out. This will ensure schools have the all necessary forms completed to maintain a safe and efficient procedure for all students.

Complete only the appropriate form(s) and submit them as soon as possible to comply with School Board Procedures.

Instructions:

1. Read the description for each form and choose which applies to your child.
2. Indicate which form(s) you need to complete by selecting the checkbox next to that form.
3. Click on the green form button in the table below and fill out the actual form. Use the **Back to Page 1** button at the bottom of each page to quickly get back to this table.
4. Repeat step 3 for the next form(s) if applicable.
5. After completing all forms that apply to your child, print completed forms and return them to your child's school.

Checkbox Select all that applies	**Form Name** Click on form button to access form	**Description**	**Pages**
☐	Medical Alert Form	Complete this **basic required** form if your child has a medical condition that needs precautionary treatment or medication at school.	**2 to 3**
☐	Request for Administration of Medication	Complete this form **ONLY** if your child needs medication administered **at school**.	**4**
☐	Anaphylaxis Emergency Action Plan	Complete this form **ONLY** if your child needs an **anaphylaxis** emergency action plan*.	**5 to 6**
☐	Diabetic Action Plan	Complete this form **ONLY** if your child needs a **diabetic** action plan*.	**7 to 8**

** Both the Anaphylaxis Emergency Action Plan and the Diabetic Action Plan has been collaboratively developed by Public Health, and School District No. 43.*
The information collected on this form is subject to and protected by the provisions of the Freedom of Information and Protection of Privacy Act.

SCHOOL DISTRICT #43 (COQUITLAM)

MEDICAL ALERT FORM

Medical Alert Form		SCHOOL YEAR:
Last Name:		Photo ID (Parents do not send photo unless requested)
First Name:		
Division:		
Grade:		
Birth Date:		
Care Card #		

Contact Name & Telephone Numbers

Mother/Guardian Last Name:			Father/Guardian Last Name:		
Mother/Guardian First Name:			Father/Guardian First Name:		
Home Phone#		Mother/Guardian's Work or Cell		Father/Guardian's Work or Cell	
Physician Name			Telephone Number		

Indicate what medical condition this student has that may require emergency care at school:

Describe the potential problem (include symptoms that might be observed):

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Describe the necessary action or intervention to appropriately treat this medical condition:	
Step 1	
Step 2	
Step 3	
Step 4	
Step 5	

Is medication needed? ◯ Yes ◯ No

If yes, what medication?

Prescribing Physician:

Parents must complete a **Request for Administration of Medication Form** (section below**)** if their child needs medication administered at school.

NOTE: No medication will be administered until this section of the medical form is completed. Parents need to ensure that this medication does not expire. It is the obligation of parents to keep a sufficient supply of any required medication at the school.

I have read and verified that the above information is correct.
By typing your name in the boxes below, you are digitally signing this form.

Parent/Guardian Last Name	Parent/Guardian First Name	Date

Copies to: **____Parent(s)** **____Student G4 File** **____Medical Alert Red Binder** **_____With medication**

____Nursing Support Care Plan (if necessary) **____TOC Sub book** **_____Child's Fanny Pack**

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Request for Administration of Medication for:

Complete this section **ONLY** if your child needs medication administered **at school**.

☐	If changes occur I will contact the school and provide revised instructions. I am aware I am required to update this information each September.
☐	I request that staff give medication as prescribed on this form to my child.
☐	If non-prescription medications are to be given, a note from the doctor will be provided.
☐	I agree to supply the medication to the school in the original container with the child's name, prescribing physician's and pharmacist's direction for use including dosage.
☐	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 and other personnel working with my child will need to know of my child's condition and of the medication required.

Name of medication:	Dose:	Time:	**Call parent if:**

Side Effects:

If training is required to administer the medication, please identify who has been given the training and when it was completed. Please be aware that parents/guardians are most often the trainer. However, if assistance from the Public Health Nurse is required, please contact your school nurse:

Training on:			
Trainer's Name		Training Date	
Name of Trained Person 1		Name of Trained Person 2	
Name of Trained Person 3		Name of Trained Person 4	

Parent/Guardian Last Name	Parent/Guardian First Name	Date

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Anaphylaxis Emergency Action Plan for:	
My child's anaphylaxis triggers are: ☐ Peanuts ☐ nuts ☐ milk ☐ all diary ☐ eggs ☐ shellfish ☐ fish	
Food additives (list)	
Insect stings (list)	
Medication (list)	
Others (list)	

My Child's anaphylaxis symptoms are usually:		
☐ swelling (eyes, lips, face, tongue)	☐ nausea or vomiting	Others (list below)
☐ difficulty breathing or swallowing	☐ coughing or choking	
☐ hives	☐ stomach cramps, diarrhea	
☐ fainting or loss of consciousness	☐ dizziness, confusion	

My child's emergency treatment is:

1. **Give EpiPen** **Location of EpiPen**:
2. **Call 911 and tell the dispatcher that a child is having a life-threatening anaphylactic reaction.**
3. **Call the parent, guardian or emergency contact person.**

DO NOT LEAVE THE STUDENT ALONE

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Authorization - I agree to (select those that apply):

☐	Supply the school with medications and up-to-date Epi-pen(s).
☐	Provide The Child with a medic alert bracelet and fanny-pack for Epi-pen.
☐	Ensure The Child knows his/her responsibilities for his/her own safety.
☐	Ensure The Child will have an Epi-pen on their person. (It is strongly recommended that children have Epi-pens on their person at all times.)
☐	I understand that my failure to do the above may result in an inability to implement timely emergency procedures for this potential life threatening condition.
☐	I authorize the staff of School District No. 43 and its agents, including volunteers, to execute the school's commitments as outlined within this plan.
☐	I am aware that the Public Health Nurse for the school will be informed of my child's condition and treatment and that the nurse may contact me as necessary.
☐	I give consent for the identification of The Child as a person with _____ (nature of condition/risk).
☐	I understand that this may include the display of pertinent information, including a picture of The Child in strategic locations within the school. It is understood that the reason for this display is to enable the staff of School District No. 43 and its agents to be able to respond to potential emergencies in a timely fashion. It is clearly understood that student confidentiality will be maintained wherever possible.
☐	I authorize the staff of School District No. 43 and its agents to administer the designated treatment and to obtain suitable medical assistance. I agree to assume all costs associated with the medical treatment and absolve the staff of School District No. 43 and the Coquitlam School Board of the responsibility for any adverse reactions resulting from the administration of the designated medication.
☐	If changes occur, I will contact the school and provide revised instructions. I am aware I am required to update this information as needed.

This agreement is valid from the date signed until revoked.

Parent/Guardian Last Name	Parent/Guardian First Name	Date

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Diabetic Action Plan for:

My child's information is:

- ☐ Diagnosed with diabetes (year)
- ☐ Needs supervision for: ☐ a.m. snack ☐ lunch ☐ p.m. snack ☐ blood sugar monitoring
- ☐ Recognizes symptoms and is capable of treating low blood sugar
- ☐ Wears medic alert (e.g. bracelet, necklace)

Insulin administration is responsibility of parent/child

Low blood sugar is <4 mmol/1 and is often brought on by more than usual exercise, delay in having meal, smaller than usual meal or change in insulin.

When child becomes sick at school, parent should be notified immediately. Vomiting and inability to retain food are serious situations. If unable to contact parents, call 911.

LOW BLOOD SUGAR SYMPTOMS My child's symptoms at time of LOW blood sugar reaction are usually:

☐ trembling	☐ pallor	☐ excessive hunger
☐ headache	☐ cold, clammy skin	☐ blurred vision
☐ irritability	☐ sweating	☐ dizziness
☐ fatigue	☐ nausea	☐ staggering gait
	☐ behaviour change	☐ shakiness, lack of co-ordination

Other symptoms may occur to indicate low blood sugar

LOW BLOOD SUGAR TREATMENT My child's treatment for low blood sugar symptoms or when no blood sugar level is available is:

1. **GIVE SUGAR IMMEDIATELY**

   Location of sugar treatment: ☐ on student other

2. **WAIT 10 – 15 minutes. If there is no improvement, repeat the above treatment.**

   If condition improves in 10 – 15 minutes, give a protein/carbohydrate snack such as cheese and crackers if next meal is more than one hour away. Observe child for a minimum of 30 minutes.

3. **CALL ABOVE CONTACTS IF BLOOD SUGAR LEVEL REMAINS BELOW 4 AFTER 2 TREATMENTS OR IF LOW BLOOD SUGAR SYMPTOMS CONTINUE TO EXIST**

DO NOT LEAVE THE STUDENT ALONE

IF STUDENT IS UNCONSCIOUS, HAVING A SEIZURE OR UNABLE TO SWALLOW, DO NOT GIVE FOOD OR DRINK

- Roll student on his/her side and protect from injury
- Call 911 or emergency medical services
- Inform parent or guardian

The school is not responsible for administering Glucagon

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HIGH BLOOD SUGAR SYMPTOMS	My child's symptoms at time of HIGH blood sugar reaction are usually:	
☐ headache ☐ drowsiness ☐ behaviour change	☐ frequent urge to urinate ☐ nausea/stomach pain	☐ excessive thirst ☐ dry mouth
Other (please explain)		

HIGH BLOOD SUGAR TREATMENT is

If blood sugar is over , notify parent

The school is not responsible for administering insulin.

Authorization - I agree to (select those that apply):	
☐	Provide emergency sugars and snacks for the treatment of low blood sugar.
☐	Keep a glucometer and adequate supplies for the monitoring of blood sugar levels for my child, and ensure child is aware of safe disposal of sharps and supplies.
☐	Provide child with medical alert bracelet/necklace.
☐	If changes occur, I will contact the school and provide revised instructions. I am aware I am required to update this information as needed.
☐	I am aware that the Public Health Nurse for the school will be informed of my child's condition and treatment and that the nurse may contact me as necessary.
☐	I authorize the staff of School District No. 43 and its agents, including volunteers, to execute the school's commitments as outlined within this place.
☐	I give consent for the identification of The Child as a person with _____ (nature of condition/risk). I understand that this may include the display of pertinent information, including a picture of The Child, in strategic locations within the school. It is understood that the reason for this display is to enable the staff of School District No. 43 and its agents to be able to respond to potential emergencies in a timely fashion. It is clearly understood that student confidentiality will be maintained wherever possible.
☐	I authorize the staff of School District No. 43 and its agents to administer the designated treatment and to obtain suitable medical assistance. I agree to assume all costs associated with the medical treatment and absolve the staff of School District No. 43 and the Coquitlam School Board of the responsibility for any adverse reactions resulting from the administration of the designated medication.
This agreement must be reviewed at the beginning of every school year and when changes occur.	

Parent/Guardian Last Name	Parent/Guardian First Name	Date

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