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