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	New form is available at this link.	
☐	Anaphylaxis Emergency Action Plan	Complete this form **ONLY** if your child needs an **anaphylaxis** emergency action plan*.	**4 to 5**
☐	Diabetic Action Plan	New forms are available at this link.	

** 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** (click here) 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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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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