506.1
ADMINISTRATIVE REGULATION
Information on the Medical Alert Form

The Fraser Valley Health Regional and the Chilliwack School District have collaboratively developed the Medical Alert Form for school use.

1. **WHO SHOULD COMPLETE THIS FORM?**

   It is designed for students who have:

   a) a medical condition that requires medication at school (ie, ADHD (Ritalin) to anaphylaxis (EpiPen)

   b) a medical condition that requires intervention in the event of epilepsy, diabetes, anaphylaxis (may or may not require medication)

2. **THE PURPOSE OF THE FORM**

   The Medical Alert Form provides:

   a) pertinent information on students with the above medical conditions

   b) a quick list of parental preferences in a health emergency

   c) parental request for medication to be administered at school

   d) physician authorization for the administration of medication

   e) parental release for the administration of medication

   f) for a response plan (if required)

   g) information on staff training in the administration of medication

   h) school and public health authorization

Cross Refs:

Adopted: November 12, 1980
Reviewed: November 23, 2004
Revised: February 26, 2002

3. USING THE MEDICAL ALERT FORM

The school principal or designated staff member will give the parent/guardian a Medical Alert Form to complete if they have indicated that their child has a health need that will require medication to be taken at school or that may require an emergency intervention. The parent will be provided with instructions on the completion of the form by school staff and in writing (sample letter provided). When the form is returned to the school, the public health nurse should be contacted to review the form and meet with the school principal to develop a response plan.

All documentation must be finalized prior to the administration of any medication. In some cases this may mean that the child will not attend school until the plan is complete. The administrator will designate a contact person at the school who will be responsible for collecting the form in a timely manner and informing the public health nurse.

4. RESPONSE PLANNING

a) have a training session for staff on the use of an EpiPen

b) provide school staff with information on the medication or the child's medical condition

c) design an EMERGENCY RESPONSE PLAN in conjunction with the parent and school staff

d) designate a staff member to administer and/or supervise medication

APPENDIX
INFORMATION ON THE MEDICAL ALERT FORM

SAMPLE LETTER to PARENTS

In order to meet your child's health needs at school, we appreciate you taking the time to complete this form. You have indicated that your child has a medical condition that makes it necessary for him/her to take medication at school on a regular or emergency basis or that your child has a medical condition that may require an emergency intervention.

PAGE ONE: please provide personal information on your child including their diagnosis and the name of your doctor. In the section regarding what to do if your child has an "attack" at school, please complete this if your child has a condition where this could occur. For example, a child who has epilepsy, severe allergies, diabetes or asthma. **Please sign at the bottom of the first page if you are requesting medication to be given at school.**

PAGE TWO: if your physician has recommended medication to be taken at school either on a regular basis or on an emergency basis please have the physician complete and sign Section A on this page. Section B is to be completed by the parent/guardian.

Once you have completed this form please return it to your school as soon as possible. The principal will review the information and develop a safety plan for your child. If you have any questions please call the school.

Yours truly,

School Principal

Student Picture If available

MEDICAL ALERT FORM

Name Birthdate *(Year, Month, Day)*

Parent or Guardian Home Ph. Work Ph.

Physician Phone

Diagnosis: ____________________

If your child has these conditions please check:

- ☐ Epilepsy
- ☐ Anaphylactic Shock
- ☐ Blood Disorders
- ☐ Severe Allergies
- ☐ Severe Asthma
- ☐ Other ______________
- ☐ Diabetes
- ☐ EpiPen Required
- ☐ ADHD

Parent's Comments:

____

____

If an attack does occur at school, please check off those actions that apply. Also please indicate the order in which they should be done.

Check	**Order**			
☐	☐	Call 9-1-1		
☐	☐	Call parents / guardians	Home ________	Work ________
			Cell ________	Pager ________
☐	☐	Call this emergency contact	Name ________	
			Phone # ________	
☐	☐	Administer Medication		

To request medication be administered at school (regularly or on an emergency basis) please complete the next page.

Parent Signature: ____________________

Administrator Signature: ____________________

Date Record Initiated: ____________________

Response Plan Required: ☐ Yes ☐ No

Date Reviewed	**Signature Public Health**

REQUEST FOR ADMINISTRATION OF

MEDICATION AT SCHOOL

Student Name: ____________________School Name: ____________________

A. TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Condition(s) which make medication necessary: ____________________

NAME OF MEDICATION	DOSAGE	DIRECTIONS FOR USE
1.		
2.		
3.		
4.		
Additional comments: (possible reactions, consequences of missing medication, storage duration)		Physicians Name: *(please print)* Physicians Signature: Date:

B. TO BE COMPLETED BY PARENT OR GUARDIAN – INFORMED AUTHORIZATION AND RELEASE

I request the school to give medication (must be in the original container) as prescribed on this form to my child, whose name is: ______________________. I will notify the school, in writing, promptly of any changes in medication or dosages ordered. I will provide the medications listed above.

- ☐ EPIPEN – I request that the administration of the EpiPen be provided. I understand that the service will be provided by a person without medical or nursing training. It is my responsibility as parent / guardian to provide the school with current EpiPens for my child's use and care.

____
Date

________________________________ ________________________________
Name – Parent/Guardian Signature – Parent/Guardian

C. INFORMATION & TRAINING

Prior to administration of any medication, each designated staff member who is responsible for the administration or supervision of the medication must date and sign below to indicate they have been informed of administration and/or has been trained, where required, by the public health nurse.

School Year: ___________________________

DATE	STUDENT NAME	STAFF NAME (please print)	SIGNATURE

D. AUTHORIZATION

________________________________ ________________________________

Date Principal's Name

____

Principal's Signature

E. TRAINING & PROCEDURES REVIEWED

________________________________ ________________________________

Date PHN's Name

____

PHN's Signature

(sample)

MEDICINE DISPENSING RECORD

Student's Name: ____

Designated Staff Members' Name: ________________________________

Medicine: ______________________________ Dosage: ____________________

Time to be given: ____

DATE	Initials	DATE	Initials	DATE	Initials

(sample)

MEDICINE DISPENSING RECORD

Student Name	Teacher Name	Amount	Mon	Tues	Wed	Thur	Fri

Student Name	Teacher Name	Amount	Mon	Tues	Wed	Thur	Fri

Student Name	Teacher Name	Amount	Mon	Tues	Wed	Thur	Fri

Student Name	Teacher Name	Amount	Mon	Tues	Wed	Thur	Fri

REQUEST FOR TEMPORARY ADMINISTRATION OF NON-PRESCRIPTION MEDICATION AT SCHOOL

Student Name: ____________________School Name: ____________________

TO BE COMPLETED BY PARENT / GUARDIAN
Condition(s) which make medication necessary: __________________________

NAME OF MEDICATION	DOSAGE	DIRECTIONS FOR USE
1.		
2.		
3.		
4.		
Additional comments: (possible reactions, consequences of missing medication, storage duration)		

I request the school to give medication (must be provided in the original container) as prescribed on this form to my child, _________________________ for the following dates (not to exceed 5 calendar days). I will notify the school promptly of any changes in medications needed. I will provide the medications listed above.

____
Date

_________________________________ _________________________________
Name – Parent/Guardian Signature – Parent/Guardian