MEDICAL ALERT PLANNING FORM
INFORMATION AND PLAN
WHILE IN THE CARE OF THE SCHOOL

School District No. 73 (Kamloops/Thompson)

Interior Health

*Fill out page 1 for all conditions except **anaphylaxis**, fill out page 2 if child is anaphylactic.*

For School Year _____ **MSP#** _____

PHOTO ID

Student Name: _____ Birth Date: _____ (Y / M / D)

Parent or Guardian _____ Home Phone: _____ Bus Phone: _____

Emergency Contact Name: _____ Phone: _____

Physician: _____ Phone: _____

Potentially life threatening medical condition diagnosed as: _____

1. New Condition: ☐Yes ☐No Date condition identified: _____
2. Describe the potential problem: _____

PLAN WHILE IN THE CARE OF THE SCHOOL:

To be updated annually and when the child's condition changes. The plan is updated by the student/parent, in consultation with the family physician and reviewed with principal in consultation with the public health nurse as needed.

- Symptoms to watch for are: _____
- Preventative measures: _____

Medication needed: ☐Yes ☐No Name of medication: _____

(If yes "Request for Administration of Medication at School" form Parts A, B, & C must be completed and provided to the school).

***Emergency Plan** school staff need to follow (step by step):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

INFORMATION REVIEW by parent/guardian:
(Review minimum annually)

1. _____ _____ Sign & Date
2. _____ _____ Sign & Date
3. _____ _____ Sign & Date
4. _____ _____ Sign & Date

TRAINING REVIEW:
(Review minimum annually)

1. _____ _____ Sign & Date
2. _____ _____ Sign & Date
3. _____ _____ Sign & Date
4. _____ _____ Sign & Date

School District No. 73 (Kamloops/Thompson)

ANAPHYLACTIC STUDENT EMERGENCY PROCEDURE PLAN

PHOTO ID

MSP#: _____

Anaphylactic Student Emergency Procedure Plan

Parent/Guardian please complete

Student's Name: _____

Date of Birth: _____ (Y/M/D)

Sex: ◻ Male ◻ Female

Parent/Guardian: _____

Daytime Phone: _____

Emergency Contact: _____

Daytime Phone: _____

Physician: _____

Physician Phone: _____

Physician please complete

Physician's Name: _____

Daytime Phone: _____ Fax: _____

Allergen: (Do not include antibiotics or other drugs)

◻ Peanuts ◻ Nuts ◻ Dairy ◻ Other food _____

◻ Insects ◻ Latex ◻ Other _____

Symptoms:

- Skin - hives, swelling, itching, warmth, redness, rash
- Respiratory (breathing) - wheezing, shortness of breath, throat tightness, cough, hoarse voice, chest pain/tightness, nasal congestion or hay fever-like symptoms (runny itchy nose and watery eyes, sneezing), trouble swallowing
- Gastrointestinal (stomach): nausea, pain/cramps, vomiting, diarrhea, dizzy/light headed, shock
- Other: anxiety, feeling of "impending doom", headache, uterine cramps in females

Additional symptoms: _____

Emergency Protocol

- Administer single dose, single-use auto-injector
- Call 911
- Notify Parent-Guardian
- Administer second single-dose single-use auto-injector in 10 to 15 minutes, or sooner, if symptoms do not improve or if symptoms recur
- Have ambulance transport student to hospital

Emergency Medication

NOTE: Emergency medication must be a single-dose single-use auto-injector for school setting. Oral antihistamines will not be administered by school personnel.

Name of emergency medication: _Epipen_____

Dosage: __0.3 mg_____

_____ Physician Signature

_____ Date (Y/M/D)

Anaphylactic Student Emergency Procedure Plan

Parent/Guardian please complete

Discussed and reviewed Anaphylaxis Responsibility Checklist with principal? ..... ◻ Yes ◻ No

Two single-dose single-use auto-injectors provided to schools? ..... ◻ Yes ◻ No

Student aware of how to administer? ..... ◻ Yes ◻ No

Auto-injector locations: _____

Your child's personal information is collected under the authority of the School Act and the Freedom of Information and Protection of Privacy Act. The Board of Education may use your child's personal information for the purposes of:

- Health, safety, treatment and protection
- Emergency care and response

If you have any questions about the collection of your child's personal information, please contact the school principal directly. By signing this form, you give your consent to the Board of Education to disclose your child's personal information to school staff and persons reasonably expected to have supervisory responsibility of school-age students and preschool age children participating in early learning programs (as outlined in the BC Anaphylactic and Child Safety Framework 2007) for the above purposes. This consent is valid and in effect until it is revoked in writing by you.

_____ Parent/Guardian Signature

_____ Date (Y/M/D)