



### MEDICAL INTERVENTION FORM

NOTE: NO MEDICATION WILL BE GIVEN UNTIL THIS FORM IS COMPLETED AND RETURNED TO THE SCHOOL.

NOTE: Complete an Anaphylaxis Emergency Procedure Plan for Anaphylaxis; a Type 1 Diabetes Action Plan for Diabetes Management; a Seizure Action Plan for Seizures INSTEAD of this form.

INSERT  
STUDENT  
PHOTO  
HERE

This form is to be completed by the parent or legal guardian  
**A copy of this form must accompany the student to hospital in an emergency**

<b>A. EMERGENCY CONTACT INFORMATION</b>	
<b>Student's Name:</b>	<b>School:</b>
<b>Care Card #:</b>	<b>Birthdate:</b>
<b>Address:</b>	
<b>Parent/Guardian #1:</b>	
<b>Phone #1:</b>	<b>Phone #2:</b>
<b>Parent/Guardian #2:</b>	
<b>Phone #1:</b>	<b>Phone #2:</b>
<b>Family Physician:</b>	<b>Phone:</b>
<b>Other Physician:</b>	<b>Phone:</b>
<b>Medical Condition:</b> <b>Life Threatening:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Any known allergies:</b>	
<b>DO NOT COMPLETE SECTIONS B, C, D and E FOR STUDENTS WHO ARE FOLLOWED BY NURSING SUPPORT SERVICES (NSS) – SEE NSS CARE PLAN</b>	

### B. SIGNS AND SYMPTOMS

**Please describe the signs and symptoms of your child's medical condition that staff should be aware of:**




**C. MEDICATION: IS MEDICATION REQUIRED AT SCHOOL? YES  NO**

<b>NAME OF MEDICATION:</b>	<b>DOSAGE:</b>	<b>DIRECTIONS FOR USE:</b>	<b>STORAGE LOCATION:</b>
1.			
2.			
3.			

**D. MEDICAL INTERVENTION(S):**

*Please describe the action(s) to be taken (i.e., Administering medication, calling home, calling 911). Additional Comments (possible reactions, consequences of missing medication, storage duration):*

(This section contains eight empty lines for writing.)

**E. AUTHORIZATION:**

I agree:

- To supply medication to the school in the original container with the child's name, prescribing physician and pharmacist's directions for use, including dosage.
- To supply the medication in the original container with directions for use, including dosage, if an over-the-counter medication is used.
- To keep an adequate supply of current medication at the school.
- To provide my child with a medical alert bracelet/necklace, as required.
- To contact the school and provide revised instructions if changes occur. I am aware I am required to update this information as needed and no less than annually.



- That the Public Health Nurse and or Nursing Support Services for the school may be informed of my child's condition and treatment and that the Nurse may contact me, as necessary.
- That the staff working with my child may need to know of my child's condition and/or the medication required.

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Parent/Guardian Signature

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Date

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Principal's Signature

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Date

<b>Copies:</b>	<input type="checkbox"/> <b>Student File</b>	<input type="checkbox"/> <b>Medical Alert Binder</b>	<input type="checkbox"/> <b>Educator in Charge/TTOC File</b>
	<input type="checkbox"/> <b>EA Float book</b>	<input type="checkbox"/> <b>My Education BC</b>	<input type="checkbox"/> <b>Parent(s)/Guardian(s)</b>

*The information collected on this form is subject to and protected by the provisions of the Freedom of Information and Protection of Privacy Act*

