New Westminster Schools

INSERT STUDENT PHOTO HERE

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.

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

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

B. SIGNS AND SYMPTOMS
Please describe the signs and symptoms of your child's medical condition that staff should be aware of:

New Westminster Schools

C. MEDICATION: IS MEDICATION REQUIRED AT SCHOOL? YES ☐ NO ☐				
	NAME OF MEDICATION:	DOSAGE:	DIRECTIONS FOR USE:	STORAGE LOCATION:
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):

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.

Parent/Guardian Signature	Date
Principal's Signature	Date

Copies:	☐ **Student File**	☐ **Medical Alert Binder**	☐ **Educator in Charge/TTOC File**
	☐ **EA Float book**	☐ **My Education BC**	☐ **Parent(s)/Guardian(s)**

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