COLLINGWOOD
SCHOOL

MEDICAL ALERT FORM

If your child has a life threatening and/or serious medical condition, Collingwood School requires Medical Alert Forms to be completed and submitted to the Health Center prior to the start of each school year. This is to ensure that Collingwood School Faculty, Staff, and Nurses have all the necessary information to maintain your child's safety and well-being while at school.

Please carefully complete the Medical Alert Form indicating your child's medical condition and required medications, and submit the form to the Health Center prior to the start of the new school year. For clarification on medical alert conditions, please refer to the table below.

Medical Alert Definitions and Criteria:

A medical alert condition is defined as a medically diagnosed, potentially life-threatening health condition that may require emergency medical care while at school. **Kindly note:** School Nurses must be informed of any history of the conditions listed below; however, your child will not be on the medical alert list unless their condition is ongoing and may require intervention while at school.

Medical Alert Conditions ***Include:***	Medical Alert Conditions ***Do Not Include:***
Anaphylaxis: past history of a severe allergic reaction(s) which required or may require emergency care and use of adrenalin (EpiPen) E.g.: insect bite or food allergy	Mild allergies that do not require urgent intervention or allergies to medication which can be avoided at school
Asthma: past history (within last 2 years) of episodes requiring immediate medical treatment; including those children who may need assistance in using inhalant medications	Controlled, stable asthma (needs rescue inhaler less than once/week). Stable: no hospitalizations within last 2 years
Blood Clotting Disorders: that require immediate medical care in the event of injury	Students with diagnosed weakened immunity due to illness or medications
Seizure Disorder: ongoing, requiring intervention	One-time seizure over one year ago
Heart Condition: that may require emergency intervention	N/A
Diabetes	N/A

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AGREEMENT
• I understand that this information might be shared amongst Faculty, Staff and School Nurses in the best interest of the student, while maintaining confidentiality under the Personal Information Protection Act.
• In an emergency situation, I authorize Collingwood Faculty, Staff and School Nurses to administer emergency medications such as EpiPen, asthma rescue inhaler, and Glucagon.
• I agree to assume all costs associated with the medical treatment and absolve the Faculty, Staff and School Nurses of the responsibility for any adverse reactions resulting from the administration of the designated medication.
• I understand that the Medical Alert Form and Medication Administration Form requires annual evaluation and completion by the treating physician.
• I am aware prescription medication will NOT be administered until a Physician completes the Medical Alert Form and Medication Administration Form **with the exception of EpiPen, asthma rescue inhaler, and Glucagon/Baqsimi**. These medications can be administered without Physician's note in emergency situations.
• I will supply the school with non-expired emergency medication as prescribed, with a pharmacy label attached, and will replace when medication is outdated or insufficient.
• I am aware that prescribed controlled substances (e.g. Ritalin, Adderall, Ativan) must be kept locked in the Health Centre during the school day and not with the student.
• I will provide my child with a medical alert bracelet.
• I will ensure that my child will have emergency medications (e.g. Epi-pen, inhaler, glucagon & insulin/glucometer/low treatment) with them at all times, as well as in the areas indicated in the Medical Alert Form under *Medication Requirements at School*.
• I will notify the School Nurses of any changes to my child's health status, changes in medication, or changes in health care provider. I am aware it is required to update this information verbally and/or by email, and on PCR as needed.
• I will notify the School Nurses if my child is hospitalized. I will work with the nurses to prepare for my child's return to school and will provide the school with a medical clearance note from my child's treating physician prior to returning to school.
I,____ hereby agree to the above statements.

Patient/Guardian Signature:		Date:	

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MEDICAL ALERT FORM

Student Name:		School Year:	

Birth Date:	Age:	Grade:	Gender:	Date Diagnosed:

Medical Condition

❑ Anaphylaxis ❑ Asthma ❑ Diabetes* ❑ Seizure Disorder ❑ Heart Condition ❑ Other

Other:

Symptoms:

* Please note, if your child is diabetic, you are required to also complete The Individual Care Plan for Students with Type 1 Diabetes and submit it to the Health Center prior to the start of each school year.

Treatment

Any prescription medications to be administered at school will require completion of the Medical Administration Form

❑ EpiPen ❑ EpiPen Jr. ❑ Glucagon/Baqsimi* ❑ Benadryl ❑ Ventolin

Instructions:

* Please note, if your child is diabetic, you are required to complete the Diabetes Medication Administration Form and submit it to the Health Center prior to the start of each school year along.

Medication Requirements at School

(please indicate corresponding grade)

❑	**JK – Gr. 3**	Epi-Pen, Inhaler, Other Emergency Medication: in Classroom and Health Centre
❑	**Gr. 4 – Gr. 7**	Epi-Pen, Inhaler, Other Emergency Medication: in Binder or Pencil Case
❑	**Gr. 8 – Gr. 12**	Epi-Pen, Inhaler, Other Emergency Medication: in Binder or Pencil Case

* Please note, if your child is in after school care, on sports teams, and/or takes the bus to and from school they are *also* required to have necessary ER medications in their backpack.

Notes:

Parent/Guardian Name(s):		Contact Number:	
Physician Name:		Contact Number:	
Physician Signature:		Date:	

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DIABETES MEDICATION ADMINISTRATION

Student Name:		School Year:	

Birth Date:	Age:	Grade:	Gender:	Date Diagnosed:

Glucagon **for severely low blood glucose** *given by subcutaneous or intramuscular injection*	**Baqsimi** (Nasal Glucagon) **for severely low blood glucose** *administered Intranasally for patients over 4 years of age.*
❑ 0.5 mg = 0.5 ml for students 5 years of age and under ❑ 1mg = 1.0 ml for students 6 years of age and over	❑ Administer intranasally, if no result in 15 mins administer Glucagon SQ or IM. ❑ Other:

Insulin Delivery Device

(rapid acting insulin only)

❑ Insulin pen

❑ Insulin pump

Type:

Blood Glucose Monitoring

❑ Continuous Blood Glucose Monitoring Device Type:	❑ Self-Monitoring Blood Glucose Device Type:

Insulin Sliding Scale

❑ Bolus Calculator ❑ Sliding Scale ❑ Variable Dose Insulin Scale

Additional Notes:

Parent/Guardian to adjust insulin dose for bolus calculator sheet or sliding scale: ❑ Yes ❑ No

I agree the student's diabetes can be safely managed at school within the above parameters: ❑ Yes ❑ No

Parent/Guardian Name(s):		Contact Number:	
Physician Name:		Contact Number:	
Physician Signature:		Date:	

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MEDICATION ADMINISTRATION FORM

The Medication Administration Form is to be filled out by the student's treating physician to give Collingwood School authorization to administer medications. Please return this form to the Health Center upon completion.

STUDENT INFORMATION					
Name:		Date of Birth:		Grade:	
Diagnosis:					

DISCLAIMER		
All Medications must be properly labelled in their original bottles/packaging.	Parent Initials:	
Medication's will be the responsibility of the School Nurse, delegation will include hands on training to staff or faculty by the School Nurse, as permissible by parent/guardian.	Parent Initials:	
Medication doses cannot exceed manufacturer's guidelines.	Parent Initials:	

PHYSICIAN

MEDICATIONS					
Medication	Dose	Route	Frequency/Times to be Given	Duration of Year	D/C Date
				☐	
				☐	
				☐	
				☐	
				☐	

PHYSICIAN INFORMATION		
Physician Name:	Signature:	Date:
Stamp/Contact Info:		