COLLINGWOOD
SCHOOL

MEDICAL ALERT FORMS

Completion of applicable documents will ensure that Collingwood School Faculty, Staff, and School Nurses will have all the necessary information to maintain a safe and efficient procedure for managing emergent student health concerns.

Please carefully complete only the appropriate form(s) complying with Collingwood School procedures and submit them along with your registration for the upcoming 2019/2020 school year.

Instructions:

1. Complete the Medical Alert Form and Agreement with signature.
2. Complete applicable Medical Condition Plan.
   a. ALLERGY AND ANAPHYLAXIS
   b. ASTHMA
   c. EPILEPSY
   d. HEART CONDITION
   e. DIABETIC
   f. OTHER
3. Please print and complete Medication Administration Record if a prescribed medication is to be given during school hours. Please note: physician signature not required for Epi pen and rescue asthma inhaler
4. Once Medication Administration Record is completed and signed by physician please return to the Collingwood Health Centre.

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

MEDICAL ALERT FORM

Student's Full Name				School Year:	
Birth date:	Age:	Grade:	Sex: M F	Date Diagnosed:	
Care Card Number:				Student Photo to be supplied by Collingwood School	

Medical Alert Condition(s):

Allergy/Anaphylaxis (Page 4)

Epilepsy (Page 5)

Asthma (Page 6)

Diabetes (Page 7)

Heart Condition (Page 8)

Other (e.g. Blood Disorder or autoimmune disorder) (Page 9)

MEDICATION ADMINISTRATION RECORD (Page 10)

- Mandatory completion if medication to be given.

Wears Medic Alert ID:	Yes No

IN CASE OF EMERGENCY

First Parent/Legal Guardian	Relationship	Home phone no.	Work phone no.
Address:		Same as child:	Yes No
Second Parent/Legal Guardian	Relationship	Home phone no.	Work phone no.
Address:		Same as child:	Yes No
Alternate Guardian/Emergency Contact	Relationship	Home phone no.	Work phone no.
Alternate Guardian/Emergency Contact	Relationship	Home phone no.	Work phone no.

AGREEMENT

Yes No	I understand that this information will be shared amongst Collingwood School staff in order for best care possible to be administered in a timely fashion.
Yes No	I authorize Collingwood School to follow guidelines within established plan of care and administration of emergency medication if required/medication administration record completed.
Yes No	I authorize Collingwood School to administer designated treatment and to obtain suitable medical assistance. I agree to assume all costs associated with the medical treatment and absolve Collingwood school of the responsibility for any adverse reactions resulting from the administration of the designated medication.
Yes No	I understand that the Medical Alert Form and Medication Administration Record requires annual evaluation. Completion of Medical Administration Record requires physician signature for medications **other than** Epi Pen and rescue inhalers that require administration during the school day.
Yes No	I am aware that NO medication will be administered until a physician completes the Medication Administration Record- **except for** Epi Pen and Asthma rescue inhalers
Yes No	I will supply the school with non-expired emergency medication as prescribed with a pharmacy label attached and will replace when outdated or insufficient.
Yes No	I will provide at least two Epi Pens, one to be carried on our child at all times and one to be kept at the Health Centre. It is the parent's responsibility to provide a safe carrying case for the EpiPen; generally in a hip-sack or belt-clip.
Yes No	I am aware that prescribed controlled substances (e.g. Ritalin, Adderall, Ativan) must be kept in the Health Centre during the school day and not with the student. School must receive physician's order if medication to be administered during school day
Yes No	I will provide my child with a medic alert bracelet.
Yes No	I will ensure that our child is aware of their responsibilities for maintaining own safety.
Yes No	I will ensure that my child will have emergency medications (e.g. Epi-pen, inhaler, & insulin/glucometer/low treatment) with them at all times.
Yes No	I understand that my failure to do the above may result in an inability to implement timely emergency procedures for this potential life threatening condition.
Yes No	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 I am required to update this information verbally and on PCR as needed.

If no, for any of the above, please state why:

This agreement is valid from the date signed until revoked.

Patient/Guardian signature		Date	

ANAPHYLACTIC ALLERGY

Student's Full Name		School Year:	

Allergens				Additional Information:
	Peanuts Tree Nuts	Egg Mustard	Insects Fruit	
	Sesame Soy	Wheat Sulphites	Drugs Other	
	Seafood Shellfish	Milk Latex	Other Other	

SEVERE Symptoms
Lung (shortness of breath, wheezing, repetitive cough)
Heart (pale or bluish skin, faintness, weak pulse, dizziness)
Throat (tight or hoarse throat, trouble breathing or swallowing)
Mouth (significant swelling of the tongue or lips)
Skin (many hives over body, widespread redness)
Gut (stomach pain, repetitive vomiting, severe diarrhea)
Other (feeling something bad is about to happen, anxiety, confusion)
EPI-PEN LOCATION #1:
EPI-PEN LOCATION #2:
EPI-PEN LOCATION #3:
Can student self-administer Epi-Pen? ❑ Yes ❑ No

If no Epi-Pen at School, please provide reason:

MILD Symptoms
Nose (itchy or runny nose, sneezing)
Mouth (itchy mouth)
Skin (a few hives, mild itch)
Gut (mild nausea or discomfort)

For mild symptoms from a single system area, follow directions:

1. Antihistamines may be given if ordered by a healthcare provider.
2. Stay with student; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

Standard Emergency Plan for Anaphylaxis:

1. Administer Epi-Pen for any of the severe symptoms listed above or 2+ mild symptoms from more than one system area.
2. Call 911 & tell dispatch "anaphylactic reaction"
3. Treat for shock (laying down with feet elevated or in recovery position if vomiting or unconscious & blanket)
4. If symptoms do not improve, or return, more doses of epinephrine can be given about 5 minutes or more after last dose.
5. Alert Emergency contacts.
6. Ambulance transport to ER with an adult.

ASTHMA

Student's Full Name		School Year:	

Triggers				Additional Information:
	Smoke Virus	Exercise Food	Pollen Mold	
	Animal dander	Air pollution	Strong smells	
	Dust mites	Weather Emotions	Other Other	

How often does your child experience asthmatic episodes?
Daily Weekly Seasonally
Other:
Have they been to hospital/ER within the last year due to asthma? No Yes Click or tap to enter a date.
If no Inhaler at School, please provide reason:

SYMPTOMS your child experiences:	
Coughing	Shortness of breath
Chest tightness	Sleepy or tired
Wheezing Pale skin	Rapid breathing Other:

Severe Asthma Symptoms:

- Skin sucking in between ribs, or base of throat
- Coughing or wheezing non-stop
- Trouble walking or talking
- Blue/gray lips or fingernails
- Stops playing and can't start activity again
- SPO2 <90%RA
- If reliever medicine not lasting 4 hours

<u>Standard Emergency Plan for Asthma:</u>

1. Stay with student.
2. Check medication administration record and give bronchodilator medication as prescribed.
3. Repeat treatment in 10 minutes if symptoms persist.
4. If attack is Severe or no medication on board: Call 911
5. Notify parent/guardian

EPILEPSY

Student's Full Name		School Year:	

Triggers				
	Stress Hormones	Food Caffeine	Low Blood Sugar Fever or other illness	Flashing lights or patterns
	Medication (e.g. Benadryl)	Missed dose of medication	Sleep deprivation	Other
	Additional Information: Date of Last Seizure: Click or tap to enter a date.			

Classification of Seizure

Focal Onset

Focal Aware Seizure (PKA Simple Partial)

Focal Impaired Awareness (PKA Psychomotor or Complex Partial)

Generalized Onset

Tonic Clonic Seizure (PKA Grand Mal)

Absence Seizure (PKA Petite Mal)

Clonic Seizure

Tonic Seizure

Atonic Seizure

Myoclonic Seizure

Unknown Onset

- ❑ Motor (e.g. tonic-clonic)
- ❑ Non-motor (e.g. absence)

Warning Symptoms

Odd feelings, often indescribable

Unusual smells, tastes, or feelings

Unusual experiences (e.g. "out-of-body"; detached; looks/feels different; situations or people look familiar or strange)

Feeling spacey, 'fuzzy', or confused

Periods of forgetfulness or memory lapses

Daydreaming episodes

Jerking movements of an arm, leg, or body

Falling

Tingling, numbness or feelings of electricity in part of the body

Headaches

Unexplained confusion, sleepiness, weakness

Losing control of urine or stool unexpectedly

Length:	**Frequency:**

Student's response after a seizure:

Additional Information:

Standard Response Plan for Epilepsy:

1. Protect student: Do not restrain or put anything in mouth.
2. If able, place in recovery position.
3. Stay with student until fully conscious.
4. Record/time activity.
5. If ordered, administer Emergency medication as per Medication Administration Record.

Call 911 if:

1. Convulsive seizure lasts longer than ☐ minutes.
2. Student has repeat seizure without regaining consciousness.
3. Student has first-time seizure.
4. Student has breathing difficulties.

If your child requires emergency medication for seizures please complete Medication Administration Record (p .10) with physicians signature.

DIABETES

Student's Full Name:		School Year:	

Emergency Kit Location(s):

Insulin Pump Brand: Insulin Pen	Short Acting Insulin Brand: Long Acting Insulin Brand:

Daily Schedule of Routine Diabetes-Related Tasks

TIME	Meal/Snack	BG Check	Insulin	Comments

LEGEND: **A** (assistance required); **S** (with supervision); **I** (independent); **BG** = blood glucose/sugar

LOW BLOOD SUGAR Symptoms

Shakiness Irritable/grouchy	Dizziness Sweating
Weakness/fatigue Pale skin Confusion	Blurry Vision Headache Hunger
Other:	

HIGH BLOOD SUGAR Symptoms

Extreme thirst Irritable	Frequent urination Hunger
Warm/flushed skin Abdominal pain	Blurry Vision Headache
Other:	

Mild Hypoglycemia (Low Blood Sugar)
Check, Treat, Repeat:

If Blood Sugar (BG) under 4mmol/L (or under 5mmol/L with symptoms)

↓

Treat with 10g to 15g of fast acting sugar, then repeat BG check after 10-15minutes

↓

Treat again if still under 4mmol/L

↓

Treat and repeat this cycle until the BG is 4mmol/L or more

↓

If BG above 4mmol/L and meal or snack is more than 1 hour away, give snack now.

Mild Hyperglycemia (High Blood Sugar)
Treatment:

Call parent/guardian if BG is above _____mmol/L, or if student is unwell (rapid/shallow breathing, vomiting, fruity breath).

Standard Emergency Plan for hypoglycemia Diabetics:

If losing consciousness or unconscious, seizure activity, unable to swallow safely…

1. Call 911 & tell dispatch student is "Type 1 Diabetic."
2. Administer Glucagon if trained and Medication Administration Record completed.
3. Alert Emergency contacts.

Please have physician complete and sign Diabetes Medication Administration form (p. 11) if glucagon is to be administered by school personnel in emergency situations

HEART CONDITION

Student's Full Name		School Year:	

Heart Condition		Additional Information:
	Cardiomyopathy:	
	Kawasaki Disease:	
	Arrhythmia:	
	Hypertension	
	Hypotension	
	Other:	
	Other:	

SYMPTOMS your child experiences:

		Have they been to hospital/ER within the last year due to Heart Condition?
		No Yes Click or tap to enter a date.
Fatigue Lightheaded/dizzy Fainting Nausea Pallor Coldness or Pain in extremities Gastric motility problems	Headache Chest Pain Shortness of breath Heart palpitations Diminished concentration Shaking Other: Other:	**If medication is to be given at school, please refer to Medication Administration Record (p. 10) for Physician order.**

Interventions recommended by Physician:

Standard Emergency Plan for Heart Condition if interventions unsuccessful:

1. Stay with student.
2. Call 911
3. Notify parent/guardian

OTHER

Student's Full Name		School Year:	

Name of Condition:	
Date of Diagnosis:	
Additional information:	

SYMPTOMS	
❑	❑
❑	❑
❑	❑
❑	❑

Refer to Medication Administration Record (p. 10) for Physician order if prescribed medications required during school hours.

Interventions recommended by Physician:

Standard Emergency Plan if interventions unsuccessful:

1. Stay with student
2. Call 911
3. Notify parent/guardian

MEDICAL ADMINISTRATION RECORD

Student's Full Name			School Year	
Primary Contact		Home #	Cell #	
Medical Diagnosis				
Allergies				

Medications taken at home:

TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Controlled substances are to be kept in Health Centre

Medication Name	Dosage	Route	Frequency	Storage
1.				❑ Health Centre ❑ With Student ❑
2.				❑ Health Centre ❑ With Student ❑
3.				❑ Health Centre ❑ With Student ❑

❑ The student is capable of self-administering the prescribed medication.
❑ The student requires supervision with self-administering prescribed medication.
❑ The student requires full assistance with administering prescribed medication.

Additional comments (possible reactions/side-effects/consequences of missed doses):

❑ Yes ❑ No	I authorize the exchange of information between my child's Physician and the School Nurse with regard to medication and medical alert condition.
❑ Yes ❑ No	I will notify the School Nurse promptly of any changes in medications.

Parent/Guardian Signature:		Date	
Physician Name:		Contact #	
Physician Signature:		Date	

DIABETES ADMINISTRATION RECORD

Glucagon

❑ 0.5 mg=0.5mL for students 5 yrs of age & under	❑ 0.1 mg = 1.0 mL for students 6 yrs of age & over

Blood Glucose Monitoring

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

Insulin (Rapid Acting Insulin ONLY)

❑ Insulin Pen (Insulin may be administered at lunchtime only)

❑ Insulin Pump (Insulin can be given if needed at recess, lunch and two hours after lunch only)

Insulin Calculation Method

❑ 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 Signature:		Date	
Physician Name:		Contact #	
Physician Signature:		Date	