Medical Action Plan 2023 / 2024

Students Name: _____

Date of Birth: _____ Grade for 2023/2024 School Year: _____

STUDENT PICTURE HERE

Please circle all that apply:

Allergy Asthma Medical Condition Other

General Details:

_____

_____

EMERGENCY CONTACT INFORMATION

Parent Emergency Contact Phone Numbers:

- Parent #1 Name and Number: _____
- Parent #2 Name and Number:_____
- Doctor's Name and Number:_____

Emergency Contacts if parents are not available**:**

- Contact #1 Name, Relationship & Phone Number:_____
- Contact #2 Name, Relationship & Phone Number:_____

Allergy Information

EpiPen**:** Yes / No (Please circle one) Expiry date (if yes) M_ _D_ _Y_ _ _ _

Please Note: For children with EpiPen's, parents must provide the school with 2 EpiPen's. 1 will be kept in your child's classroom, and one must be in a fanny pack with the student at all times. In addition to these 2 there is an emergency epipen in the office at all times.

ALLERGY SYMPTOMS / PRESENTATION (PLEASE CHECK ALL THAT APPLY)

General Symptoms : Please check mark or cross off as pertinent to your child. and list any additional details specific to your child during a reaction

- Itching and swelling of the lips, tongue, mouth
- Itching and swelling of face and eyes
- A Sense of tightness in the throat or chest
- Hives and/or itchy rash on face or extremities
- Shortness of breath, repetitive coughing and/or wheezing
- Loss of consciousness
- Fear and/or panic

Additional Information pertaining to my child: _____
_____
_____

EMERGENCY ACTION :

Below is the standard emergency action plan when an anaphylactic allergy takes place. Please note any specifics or changes your child may require

1. Use EpiPen immediately.
2. DESIGNATE SOMEONE TO CALL AN AMBULANCE and advise the dispatcher that a student is having an anaphylactic reaction (a severe life-threatening allergic reaction).
3. Call parent/guardian.
4. If ambulance has not arrived in 15 minutes and breathing difficulties are present or student is unconscious, give second EpiPen.
5. This student must be taken to a hospital immediately even if symptoms subside entirely.
6. Send second EpiPen with the ambulance if it has not been administered.

Additional Information pertaining to my child: _____
_____
_____

ALLERGY POLICY (signature required)

I realize that it is my responsibility to:

1. Provide both the school and the student with one in-date EpiPen each (two in total) to use at school if applicable.
2. Ensure that my child carries his/her EpiPen at all times and that the second EpiPen will be administered in the event that the ambulance hasn't arrived within 15 minutes of the first application and breathing problems persist.
3. Alert the school to my child's anaphylactic allergies by completing the Allergy Action Plan, the request for administration of medication form prescribed upon registration of my child and each September if my child is a returning student.
4. Replace the EpiPen in advance of the listed expiry date.
5. Provide a picture of my child to the office each September.
6. Call the school to schedule a meeting with the teacher/principal to discuss my child's anaphylactic reactions protocol if I so desire.

I GIVE PERMISSION TO THE SCHOOL PRINCIPAL TO POST MY CHILD'S PICTURE AND A COPY OF THIS FORM ANYWHERE IN THE SCHOOL SO THAT ALL STAFF IS ALERTED TO THIS SITUATION.

I ACKNOWLEDGE THAT NON-MEDICAL PERSONNEL ARE BEING ASKED TO UNDERTAKE THE ADMINISTRATION OF MEDICATION OR MEDICAL PROCEDURES TO MY CHILD. I UNDERSTAND THAT THERE IS SOME INHERENT RISK IN HAVING NON-MEDICAL PERSONNEL UNDERTAKE THE ADMINISTRATION OF MEDICATIONS AND PROCEDURES, AND ACCEPT THE RISKS ASSOCIATED WITH THIS REQUEST.

I ACKNOWLEDGE THAT ANY COSTS INCURRED IN AN EMERGENCY SITUATION WILL BE THE RESPONSIBILITY OF THE PARENTS.

Parent /Guardian Signature: _____

Date: _____

Asthma Information

Please list all puffers / medications child take:

1. _____
2. _____
3. _____
4. _____

Does the office have an aerochamber for this child to receive their puffers? _____

Please list detailed instructions:

_____
_____
_____
_____
_____

ASTHMA POLICY (signature required)

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I ACKNOWLEDGE THAT NON-MEDICAL PERSONNEL ARE BEING ASKED TO UNDERTAKE THE ADMINISTRATION OF MEDICATION OR MEDICAL PROCEDURES TO MY CHILD. I UNDERSTAND THAT THERE IS SOME INHERENT RISK IN HAVING NON-MEDICAL PERSONNEL UNDERTAKE THE ADMINISTRATION OF MEDICATIONS AND PROCEDURES, AND ACCEPT THE RISKS ASSOCIATED WITH THIS REQUEST.

I ACKNOWLEDGE THAT ANY COSTS INCURRED IN AN EMERGENCY SITUATION WILL BE THE RESPONSIBILITY OF THE PARENTS.

Parent /Guardian Signature: _____

Date: _____

Medical Conditon Information

Please list any other medical information here:

_____
_____
_____
_____
_____

MEDICAL CONDITION POLICY (signature required)

I ACKNOWLEDGE THAT NON-MEDICAL PERSONNEL ARE BEING ASKED TO UNDERTAKE THE ADMINISTRATION OF MEDICATION OR MEDICAL PROCEDURES TO MY CHILD. I UNDERSTAND THAT THERE IS SOME INHERENT RISK IN HAVING NON-MEDICAL PERSONNEL UNDERTAKE THE ADMINISTRATION OF MEDICATIONS AND PROCEDURES, AND ACCEPT THE RISKS ASSOCIATED WITH THIS REQUEST.

I ACKNOWLEDGE THAT ANY COSTS INCURRED IN AN EMERGENCY SITUATION WILL BE THE RESPONSIBILITY OF THE PARENTS.

Parent /Guardian Signature: _____

Date: _____