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 <u>INSTEAD</u> 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

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:

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

	NAME OF MEDICATION:	**DOSAGE:**	**WHERE KEPT?**	**Prescribed for:**	**Directions for use (see Section D)**
1.					
2.					
3.					

D. MEDICAL INTERVENTION(S):
Please describe the action(s) to be taken (i.e. Administering medication, calling home, calling 911):

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 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 completed: _____

Principal's signature: _____ Date completed: _____

Copies: ☐ **Parent(s)** ☐ **Student File** ☐ **Medical Alert Binder** ☐ **TTOC File** ☐ **Student Information System Inputted**

June 2015.
This Medical Intervention Form has been collaboratively developed by Fraser Health, Maple Ridge, and School District No. 42. The information collected on this form is subject to and protected by the provisions of the Freedom of Information and Protection of Privacy Act.

Administration of Medication Record

Top section to be completed by Parent(s)/Guardian(s)

Student Name: _____

Medication Name: _____

Directions for Use (per prescribing physician and pharmacist's direction): _____

_____

Dosage: _____

Schedule of administration: _____

Parent/Guardian Signature: _____ Date Signed: _____

DATE	TIME	SIGNATURE	DATE	TIME	SIGNATURE

June 2015