AP-I-801.1.1 Administration of Medical Treatment/Medications & Medical Management Plan

Administrative Procedures

The personal information on this form is collected under the authority of Alberta's *Education Act*, the *Student Record Regulation* and the *Freedom of Information and Protection of Privacy Act*. The collection aims to respond to medical situations involving your child whom you have identified as subject to a medical condition where a plan needs to be developed to support a child in taking prescribed medication during the school day or is a serious or potentially life-threatening allergy or medical condition. If you have any questions concerning the collection, use, or disclosure of this information, please contact your campus principal. Please refer to *AP-I-801.1 Responding to Students with Medical Needs* for further details on FFCA's procedures.

STUDENT INFORMATION: [Parent/guardian to complete]

Student's Legal Name (First/Last): ____

Student's Preferred Name (If different from Legal Name): ______________________________

Date of birth (mm/dd/yyyy): _______________

**Students with potentially life-threatening diagnosed medical conditions are strongly recommended to wear an appropriate Medic Alert item that indicates their condition and emergency contact.

Medic Alert I.D (if applicable): ____

Identify Medic Alert item: ____

Parent/guardian: ____

Relationship: ____________ Daytime ph: ____________

Parent/guardian: ____

Relationship: ____________ Daytime ph: ____________

Physician: ____

Daytime ph: __________

Other Healthcare Provider: __________________________________

Daytime ph: __________

MEDICAL MANAGEMENT PLAN:

To be completed in consultation with the Principal Educator, parent/guardian(s), the student, and additional medical professionals (If deemed necessary by either the campus or parent). Only the information that applies to the student's medical condition is required. If the child has **Type 1 Diabetes, complete the Individual Care Plan instead**. If additional medical professionals are required, complete the optional Medical Professional form.

If Anaphylaxis, indicate the allergen(s):____

____

Reaction to allergen may be caused by: ❐ physical contact ❐ ingestion
❐ airborne contact ❐ insect sting/bite

Symptoms of allergic reaction: ____

____

Recommended response to allergic reaction (include time factor): ______________________

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❐ My student has an allergy requiring an epi-pen. The epi-pen and supplies/medication are in close proximity to your child and easy to access. As such, it is recommended that your student keep the epi-pen in a fanny pack and wear it at all times with all required supplies/medications. Additionally, all supplies/medication needs to travel to/from school, and contents will be checked by parent/guardian daily. My child's epi-pen will be located: ______________________.

If other medical condition requires the storing/ support with medication at school or serious or life-threatening condition, indicate the diagnosed health condition: ____

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Signs/symptoms: ____

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Strategies for managing above symptoms: ____

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Monitoring (signs/symptoms to be reported and method of reporting): ______________________

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Triggers & restrictions (list anything that should be avoided): ______________________

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- ❒ My student has a condition requiring emergency medication. It is essential that the supplies/medication are in close proximity to your child and easy to access. As such, it is recommended that your student keep the supplies/medications in a fanny pack and wear it at all times. Additionally, all supplies/medication needs to travel to/from school, and contents will be checked by parent/guardian daily. My child's supplies/medication will be located: ____.

I have provided the campus with a supply of medication prescribed to my student and will ensure it is replaced as needed and in a timely manner. *We highly recommend this for anaphylaxis.

- ❒ Medication: ___________________________ Dosage: __________
- ❒ Medication: ___________________________ Dosage: __________
- ❒ Medication: ___________________________ Dosage: __________
- ❒ Medication: ___________________________ Dosage: __________

Medication side effects, including adverse reactions: ____

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Procedure to follow in case of adverse reaction to medicine: ____

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Additional medication information (security requirements, termination date of administration, other):

____

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List steps to take in the event of an emergency related to this condition: __________________________________

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Accommodations and Special Considerations

Taking into consideration facility and staffing limitations and in consultation with the Principal Educator, parent(s), student, list any accommodations to be made at the campus that will assist this student in participating as fully as possible in all aspects of school and events.

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- ❐ In the event that my student's health, medication and/or treatment changes, I will immediately inform the campus and provide any updated form(s) completed by the Physician and schedule an appointment to review/update this Medical Management Plan with relevant staff.
- ❐ I am aware that FFCA staff are not medical professionals. Staff will act in good faith and will follow the procedures authorized on this form and any attachments to the best of their abilities.
- ❐ I understand that 9-1-1 may be called based on the judgement of involved staff and that if an incident happens on the bus, 9-1-1 will be called.

FFCA Office Use Only

Staff member authorized to administer medication:

_____________________________ ____
(Print Name) (Signature)

Alternate staff member authorized to administer medication:

_____________________________ ____
(Print Name) (Signature)

Alternate staff member authorized to administer medication:

_____________________________ ____
(Print Name) (Signature)

AUTHORIZATION:

This Medical Management Plan was developed on the following date: __________________.

This plan remains in effect for the _____ to _____ school year.

Parent/Guardian signature: _____________________________________ Date: ________________

Parent/Guardian name (print): __________________________________ Relationship: __________________

Parent/Guardian signature: _____________________________________ Date: ________________

Parent/Guardian name (print): __________________________________ Relationship: __________________

Student signature: ____ Date: ________________

Principal Educator signature: ___________________________________ Date: ________________

Principal Educator (print): __________________________________

ANNUAL REVIEW:

When requirements change, complete a new Medical Management Plan and share with all involved.

If there are no changes between school years, use this sign-off sheet to confirm the plan has been reviewed by the campus, the parent/guardian(s), and, when age-appropriate, the student.

This plan remains in effect for the _____ to _____ school year without change.

Parent/Guardian signature: ____________________________________ Date: ________________

Principal Educator signature: ___________________________________ Date: ________________

This plan remains in effect for the _____ to _____ school year without change.

Parent/Guardian signature: ____________________________________ Date: ________________

Principal Educator signature: ___________________________________ Date: ________________

This plan remains in effect for the _____ to _____ school year without change.

Parent/Guardian signature: ____________________________________ Date: ________________

Principal Educator signature: ___________________________________ Date: ________________

This plan remains in effect for the _____ to _____ school year without change.

Parent/Guardian signature: ____________________________________ Date: ________________

Principal Educator signature: ___________________________________ Date: ________________

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Parent/Guardian signature: ____________________________________ Date: ________________

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Parent/Guardian signature: ____________________________________ Date: ________________

Principal Educator signature: ___________________________________ Date: ________________

This plan remains in effect for the _____ to _____ school year without change.

Parent/Guardian signature: ____________________________________ Date: ________________

Principal Educator signature: ___________________________________ Date: ________________

Optional Medical Professional Form:

In case of less known or complex medical conditions, FFCA recommends that other medical professionals provide any additional information that would be helpful for the campus to be aware of in case of emergency. If deemed necessary by the Principal Educator or parent/guardian, have the following completed by the appropriate Physician.

PHYSICIAN INFORMATION: [Physician to complete, attached separate sheet if details lengthy]

PATIENT NAME (legal and preferred, if applicable): ____

If only Type 1 Diabetes: Physicians, do NOT fill in this form. Please fill in the ICP for Students with Type 1 Diabetes form specifically for diabetic patients and attach it to this form.

If Anaphylaxis, indicate the allergen(s):____

____

Reaction to allergen may be caused by: ❐ physical contact ❐ ingestion ❐ airborne contact ❐ insect sting/bite

Symptoms of allergic reaction: ____

____

Recommended response to allergic reaction (include time factor): __________________________

____

If other serious or life-threatening condition, indicate the diagnosed health condition: ______________

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Signs/symptoms: ____

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Strategies for managing above symptoms: ____

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Monitoring (signs/symptoms to be reported and method of reporting): __________________________

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Triggers & restrictions (list anything that should be avoided): ________________________________

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Name of medication and/or treatment: ____

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Dosage and procedure for administration: ____

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Time interval for administration: ____

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Medication side effects, including adverse reactions: ______________________________

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____

Procedure to follow in case of adverse reaction to medicine: ______________________

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____

Additional medication information (security requirements, termination date of administration, other):

____

____

List steps to take in the event of an emergency related to this condition: ______________

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____

Accommodations and special considerations that will assist student in participating as fully as possible:

____

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Next review date (on or before): ____________________ Last date of treatment: ________________

Physician name: ____ Daytime ph: _____________

Office name and address: ____

Physician signature: ____ Date: __________________