AP-I-801.1.1 Administration of Medical Treatment/Medications

Administrative Procedures

March 28, 2012

The personal information on this form is collected under the authority of the School Act, the Student Record Regulation and the Freedom of Information and Protection of Privacy Act. The purpose of the collection is to respond to potential emergency situations involving your student whom you have identified as subject to a potentially life threatening allergy or medical condition. If you have any questions concerning the collection, use, or disclosure of this information, please contact your school principal either in writing or by telephone.

STUDENT INFORMATION [*To be completed by parent/guardian*] **Please print**

Name of student: ____ Date of birth: ____________________________

Address: ____

Home phone: ____ Medic Alert I.D.: __________________________

Parent/guardian: ____ Daytime phone: ___________________________

Parent/guardian: ____ Daytime phone: ___________________________

Emergency contacts (other): ____________________________________ Daytime phone: ___________________________

Physician: ____ Daytime phone: ___________________________

It is strongly recommended that students with known medical conditions, including potentially debilitating allergies, wear an appropriate wristband or pendant that indicates the nature of the condition, and an emergency phone number.

- ❒ My child ______________________(name) wears a Medical Alert ***bracelet/pendant*** (please circle) identifying the following condition(s): ____
- ❒ In the event of an emergency, I give permission to follow the procedures authorized by my child's physician on the following page.
- ❒ I have provided the school office with an unexpired supply of the medication (including inhaler, injector or epi-pen) prescribed for my child by his/her physician.
- ❒ My child has an allergy requiring an epi-pen and has his/her epi-pen available at all times, including transportation to and from school.
- ❒ In the event that my child's health, medication and/or treatment changes, I will immediately inform the office and provide them with an updated form completed by his/her physician.
- ❒ I authorize FFCA staff to share this information and that on the *Physician Information* form with the bus carrier if the student is a bussed student.

Name of parent/guardian: ____ Daytime phone: ___________________

Parent/guardian signature: ____ Date: _____________________________

Signature of Campus Principal Educator____

Name of staff member authorized to administer medication:____

Signature of staff member authorized to administer medication:____

Name of alternate staff member authorized to administer medication:____

Signature of alternate staff member authorized to administer medication:____

PHYSICIAN INFORMATION [***To be completed by physician***] **Please print**

PATIENT NAME____

Allergy/Allergens: ____

Anaphylactic reaction may be caused by: ❒ physical contact with this allergen ❒ ingestion of food
❒ airborne contact with this allergen ❒ bee/wasp/hornet sting

Symptoms of allergic reaction: ____

____

____

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

____

____

Other Medical Condition(s) (Crohn's, Diabetes, Epilepsy, etc.): ______________________________

____

Signs/symptoms (attached separate sheet if details lengthy): ____________________________________

____

____

Name of medication and/or treatment: ____

____

____

Dosage and procedure for administration: ____

____

____

Time intervals for administration: ____

____

____

Possible side effects, including adverse reactions: ____

____

____

Procedure to follow in case of adverse reactions: ____

____

____

Additional Instructions or Information (security requirements, termination date of administration, other):

____

____

Name of physician: ______________________________________ Phone: ______________________

Signature of physician: ___________________________________ Date: _______________________