



EDMONTON
CATHOLIC SCHOOLS

MEDICAL ALERT

(Post in a staff area for ALL staff.)

(Used as per Admin. Procedure 316, (Appendix E)

(The information on this form is to correspond with the Request for Administration of Medication/Medical Treatment Form)

Student Name

Grade

Teacher

Medical Condition

Symptoms of Reactions

Photograph of Student

DO THIS IMMEDIATELY

Staff who know how to help student

Medical treatment

Name of medication

Dosage

Method of administration

Location of medication

Administer within minutes

If no relief

Possible side effects

N.B. For life-threatening reactions call 911 for Ambulance



EDMONTON
CATHOLIC SCHOOLS

REQUEST FOR ADMINISTRATION OF MEDICATION/MEDICAL TREATMENT

Used as per:
Admin. Procedure 316 (Appendix A, B C, D and E)

(Retain copy of Page 1 and Page 3 in Emergency File to accompany student on all field trips.)

The following information will be used for the purposes of responding to the medical needs of your child. (All information should be printed)

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____ Principal: _____

Parent/Guardian Name: _____

Address: _____

Telephone: Home _____ Day No. (Mother) _____ Day No. (Father) _____

Other Emergency Family Contact: Name: _____

Telephone: _____ Relationship: _____

Alberta Personal Health Care Number (optional): _____

MEDICAL INFORMATION

1. Medical intervention which is being requested of school staff (Please check)

____ Medication administration

____ Life-threatening allergic reaction to _____

Medical Procedure: _____

2. Purpose of Intervention: _____

3. Medical Profile (please include all medications your child takes - attach list if necessary)

Name of Medication	Dosage	Time(s) of Day	Start Date Year/month/day	End Date Year/month/day	Symptoms: Reactions/Side effects

4. Student is able to self-administer: Yes _____ No _____

5. Special Storage Information: _____

6. Emergency procedure in event of reaction: _____

7. Designate medical facility/hospital in the event of an emergency: _____

Physician Name: _____ Physician's Telephone: _____

I am providing this information to assist in responding appropriately to the medical needs of my child during school hours. This information will be shared with school and bus transportation staff on a need to know basis.

(Parent/Guardian Signature)

(Date)

Authorization for the Administration of Medication/Medical Treatment

This Authorization is Subject To the Following:

- The parent or legal guardian is to provide the medication or medical supplies as prescribed or determined by the student's physician and specific details pertaining to the administration of the medical treatment (Administrative Procedure 316, Appendix A, B, C, D and E).
- The medication and certain medical supplies are to be provided in the original container.
- For medical equipment, complete and clear instructions as to its proper use are to be provided. The good working order of these devices will be the responsibility of the parent.
- The parent or legal guardian is to provide instruction on the proper administration of medication intervention as per Administrative Procedure 316.
- The parent is to provide instruction on the proper administration of the medical treatment after having received instruction from his/her medical practitioner/health professional (as necessary).
- The parent/legal guardian is to repeat and update this instruction should:
 - the student's medical condition change
 - the intervention requirements change
 - there be a change in school staff assisting the student in the medical intervention
 - the assisting staff request a review or refresher of the medical intervention

I have provided the above and completed the required instruction at (location) _____
on (date) _____.

This session was attended by the following school staff.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Parent/Guardian Signature

YR

MO

DAY

CONFIRMATION FROM STUDENT'S PHYSICIAN

I hereby confirm that the following medication _____
must be administered to _____ (name of student) during school hours.

I also confirm that:

- a) The service required is of such a simplistic nature that a lay person (teacher, teacher assistant, secretary) could successfully perform the function;
- b) The service has to be performed during regular school hours and / or approved school activities;
- c) The service is critical to the well being and functioning of the student; and
- d) No other reasonable alternative is available (i.e. through a community agency).

Name of Physician

YR

MO

DAY

MEDICAL TREATMENT PROCEDURES

(TO BE FILLED OUT BY THE PARENT AND ATTENDING PHYSICIAN)

[illegible]

DAY



RELEASE FORM

Administration of Medication/Medical Treatment

The undersigned, _____, being the legal parent/legal guardian of _____, a student of the Edmonton Catholic Separate School District No. 7, do hereby request and authorize personnel employed by the District to provide necessary first aid and medical treatment to the said student, and for so doing, this will serve as a release and indemnification of and from any action or inaction of any personnel of the District associated with the rendering of first aid or administering of medical treatment to the said student. Further, the undersigned parent/legal guardian recognizes and acknowledges that the personnel employed by the School District who may, as a result of this request, be rendering first aid or administering medical treatment to the said student, are not medical practitioners.

Dated at _____, in the Province of Alberta,

this _____ of _____ A.D.,
 day month year

 Signature of Parent/Guardian

 Signature of Witness

Note: School to retain copy in student file - School to provide copy to parent/guardian.