APPENDIX I

Authorization for the collection of this information is in the Education Act. The purpose is to administer medication to students in the event of an emergency. Users of this information may be principals, teachers, support staff, volunteers, bus operators and drivers. This form will be kept for a minimum period of one school year or June 30th of each school year and then be shredded. Contact person concerning this collection is the school principal.

EMERGENCY PROTOCOL

STUDENT INFORMATION (to be completed by Parent/s) Bus Route__________

Name of Student____

Date of Birth_________________________ School Name:_________________________

Home Address____

Home Telephone______________________ Medic Alert I.D.______________________

Name of Father_______________________ Business No.__________________________

Name of Mother______________________ Business No.__________________________

Name of Guardian____________________ Business No.__________________________

STUDENT PHOTO

MEDICAL INFORMATION (to be completed by Family Physician

Medical Condition____

____

Symptoms____

____

____

____

Recommended Response____

____

____

Medication________________________________ Dosage (e.g. No. of EpiPens required)_________________________

Additional Instructions or Information____

____

____

Name of Physician (Please Print)________________________________ Telephone____________________________

Signature of Physician____ Date________________________________

LIFE-THREATENING MANAGEMENT AND PREVENTION PLAN

EMERGENCY ACTION PLAN

PARENT COMMITMENTS

At School

On Excursions

SCHOOL COMMITMENTS

At School

On Excursions

BUS OPERATOR/DRIVER COMMITMENTS

PARENT AGREEMENT

I, ______________________________, acknowledge my participation in the development of the preceding Emergency Action Plan and agree to execute reliably the parent commitments listed within them. I give my consent for the staff of ______________________ School to execute the school commitments as outlined within the plan. I understand that this plan will be reviewed annually and I will update the school if circumstances change before review.

I/We acknowledge that it is neither the objective nor purpose of the school to administer medication to students and understand that the school is prepared to undertake this activity as a last resort. In the event of an emergency, I authorize the school staff identified in the plan to administer the designated medication and obtain suitable medical assistance. I agree to assume responsibility for all costs associated with medical treatment and absolve the Near North District School Board and its employees of responsibility for any adverse reactions resulting from administration of the medication.

I give my permission for this medical information to be posted in the school, accessible on the bus, and shared with appropriate personnel.

_______________________________________ ________________________________

Parent/Guardian/Adult Student Signature

Date

PRINCIPAL WILL DIRECT COPIES TO: ☐ Parent ☐ Posted as Appropriate

☐ Teacher ☐ Bus Operator