VANCOUVER BOARD OF EDUCATION

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

A. TO BE COMPLETED BY PARENT OR GUARDIAN

NAME	BIRTHDATE (YEAR, MONTH, DAY)	
PARENT OR GUARDIAN	HOME PHONE	BUSINESS PHONE
PHYSICIAN	PHONE	

B. TO BE COMPLETED BY PRESCRIBING PHYSICIAN

CONDITIONS (WHICH MAKE MEDICATION NECESSARY)

NAME OF MEDICATION	DOSAGE	DIRECTIONS FOR USE
1.		
2.		
3.		
4.		

ADDITIONAL COMMENTS, POSSIBLE REACTIONS, CONSEQUENCES OF MISSING MEDICATION ETC.

PHYSICIAN'S SIGNATURE

DATE

C. TO BE COMPLETED BY PARENT OR GUARDIAN

I REQUEST THE SCHOOL TO GIVE MEDICATION AS PRESCRIBED ON THE FRONT OF THIS FORM TO MY CHILD WHOSE NAME IS RECORDED BELOW.

NAME OF CHILD

I WILL NOTIFY THE SCHOOL PROMPTLY OF ANY CHANGES IN MEDICATIONS ORDERED

SIGNATURE OF PARENT OR GUARDIAN

DATE

D. CONSULTATION (AS NEEDED) WITH COMMUNITY HEALTH NURSE AFTER THE COMPLETED REQUEST IS RETURNED TO THE SCHOOL AT REQUEST OF SCHOOL ADMINISTRATOR

COMMENTS

CHN'S SIGNATURE DATE

SUBSEQUENT COMMENTS, IF ANY:

SCHOOL ADMINISTRATOR DATE

E. EACH SCHOOL STAFF MEMBER WHO IS RESPONSIBLE FOR THE ADMINISTRATION OF THE MEDICATION MUST REVIEW THE INFORMATION ON THIS CARD THEN DATE AND SIGN BELOW.

DATE	SIGNATURE	COMMENTS, IF ANY

Tennyson School Nov 2011

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Children with Medical Conditions

Children with medical conditions such as seizures, asthma or diabetes should have a care plan completed and stored at the school. Parents, schools and the school public health nurse all have a role to play in keeping children safe and healthy.

Parents' role

- Make the school aware of their child's medical condition and provide updates if this condition changes.
- Assist the school in completing a care plan for their child.
- Provide appropriate medications both for management and emergency and determine a plan with the school about where and how these should be kept and administered.

Your role

- Keep a record of students who have identified medical conditions
- Ensure that care plans for students with medical conditions are updated regularly
- Consult with your school's public health nurse if you have questions about a care plan for a student.

Our role

- Act as a resource and consultant regarding complex care plans.
- Assist with referrals to appropriate professionals or organizations as needed.

Resources

- Asthma care plan
- Diabetes care plan
  - Additional diabetes resources for schools can be found on the BC Children's Hospital Endocrinology website
- Seizures care plan
- Anaphylaxis (Life Threatening Allergy) Information / Care Plan
- Request for Administration of Medication At School

Please complete forms & return to office.

Thank You

Anaphylaxis (Life Threatening Allergy) Information

Emergency Plan for ____________________

Child's Name: ____________________
Date of Birth: ____________________
Parent/Guardian: ____________________
H#: __________ W#: __________
Emergency Contact: ____________________
H#: __________ W#: __________
Physician: __________ Office #: __________

Picture ID

CHILD'S ANAPHYLAXIS TRIGGERS ARE:

☐ peanuts ☐ nuts ☐ milk ☐ all dairy ☐ eggs ☐ shellfish ☐ fish
☐ Food additives (list): ____________________
☐ Insect stings (list): ____________________
☐ Medications (list): ____________________
☐ Other: ____________________

CHILD'S ANAPHYLAXIS SYMPTOMS ARE USUALLY:

☐ swelling (eyes, lips, face, tongue)
☐ hives or itchy skin
☐ cold, clammy, sweaty skin
☐ fainting or loss of consciousness
☐ stomach cramps/diarrhea/vomiting
☐ difficulty breathing/swallowing
☐ tingling of lips/mouth
☐ coughing or choking
☐ flushed face or body
☐ dizziness, confusion
☐ change of voice
☐ heart rate changes (fast/slow)
☐ others (list): ____________________

CHILD'S EMERGENCY TREATMENT:

☐ Medication is stored where?
☐ Anti-histamine (specify brand & dosage):
☐ Epi pen – expiry date:
☐ Names of staff oriented to plan:
☐ Emergency plan review date:
☐ Field Trip Plans:

DO NOT WAIT FOR SYMPTOMS TO DEVELOP OR WORSEN

- **GIVE ____________________**
- **CALL 911**
- **STAY CALM**
- **CALL PARENTS**

Other Instructions:

____
____
____
____

Sign here if you agree with above Information & Plan

____________________ Physician ________ Date

____________________ Parent/Guardian ________ Date

____________________ Childcare Supervisor ________ Date

Vancouver Coastal Health Authority
North Shore/Coast Garibaldi, Vancouver & Richmond

Asthma Care Plan **Emergency Plan for:** ______

Facility Name: ______ **Facility Address:** ______

Child's Full Name: ______

Date of Birth: ______

Parent/Guardian: ______

Phone (home/cell): ______ Phone (work): ______

Emergency Contact: ______

Phone (home): ______ Phone (work): ______

Primary Care Provider: ______ Office Phone: ______

Picture ID

CHILD'S ASTHMA TRIGGERS ARE:

☐ change in temperature ☐ colds, infection ☐ dust, mites ☐ emotion (e.g. upset) ☐ mould ☐ physical activity ☐pollen

☐ animals (list): ______

☐ foods (list): ______

☐ strong smells (list): ______

☐ Other: ______

CHILD'S ASTHMA SYMPTOMS ARE USUALLY:

- ☐ appears anxious
- ☐ coughing
- ☐ difficulty talking
- ☐ fast/shallow breathing
- ☐ pale
- ☐ hunched over
- ☐ short of breath
- ☐ wheezing
- ☐ in-drawing/tracheal tug
- ☐ other (list below):
- ☐
- ☐

CHILD'S EMERGENCY TREATMENT:

☐ Medication is stored:

☐ Medication expiry date:

☐ Names of staff oriented to plan:

☐ Emergency plan review date (to do yearly):

☐ Field Trip Plans:

- **GIVE** ______
  (name of medication)
- **Follow Instructions:**

______

______

______

______

______

- **If unsure, child is worse or not getting better CALL 911**
- **CALL PARENTS**

It is the parent's responsibility to notify the facility of any change in the child's condition.

Sign below if you agree with above Information & Plan:

______ ______
Primary Care Provider Date

______ ______
Parent/Guardian Date

______ ______
Childcare Supervisor/School Personnel Date

Asthma Care Plan is provided as a resource from Vancouver Coastal Health – February 2011

Diabetes Care Plan **Emergency Plan for:** ____________________

Facility Name: ____________________ **Facility Address:** ____________________

Child's Full Name: ____________________

Date of Birth: ____________________

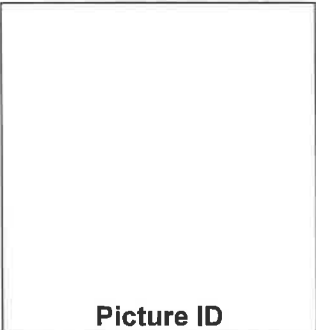
Parent/Guardian: ____________________

Phone (home/cell): __________ Phone (work): __________

Emergency Contact: ____________________

Phone (home): __________ Phone (work): __________

Primary Care Provider: __________ Office Phone: __________



Picture ID

HISTORY:

Date of Diagnosis:

How often do they get low blood sugar?

☐ Morning Snack Time: Type of Snack:

☐ Afternoon Snack Time: Type of Snack:

☐ Student wears a Medic-Alert

CHILD'S DIABETIC SYMPTOMS ARE USUALLY:

☐ irritability – mood changes, crying
☐ headache
☐ tremors, shaky body parts
☐ hunger
☐ nausea
☐ sweating, cold, moist skin
☐ dizziness
☐ tired and pale
☐ other (list below):

CARE PLAN INFORMATION:

☐ Medications (list): Medication expiry date:

☐ Location of emergency kit:

☐ Names of staff oriented to plan:

☐ Emergency plan review date (to do yearly):

☐ Field Trip Plans:

- **GIVE SUGAR IMMEDIATELY**
  - 4 oz fruit juice/pop (not diet)
  - Or 2 tsp sugar or glucose gel
  - Or 2 glucose tablets
  - Or: ____________________
- **If symptoms do not disappear within 15 minutes or child becomes unconscious call 911**
- **CALL PARENT(S)**

It is the parent's responsibility to notify the facility of any change in the student's condition.

Sign below if you agree with above information & plan:

____________________ __________
Primary Care Provider Date

____________________ __________
Parent/Guardian Date

____________________ __________
Childcare Supervisor/School Personnel Date

Diabetes Care Plan is provided as a resource from Vancouver Coastal Health – August 2011