ADMINISTRATION OF MEDICATION/MEDICAL TREATMENT TO STUDENT APPROVAL FORM

The following information will be used for the purpose of responding to the medical needs of your child. All information placed in a student's file will be protected and used in compliance with the Freedom of Information and Protection (FOIP) Act and the Health Information Act.

(All information should be printed)

Student's Name: ________________________________ Date of Birth: _________________
School: _______________Grade: ____Teacher: _______________Principal: ______________
Parent/Guardian Name: ____
Address: ____
Telephone: Home _____________ Day # (Mother) ___________Day # (Father) _____________
Other Emergency Family Contact: Name: ____
Telephone: _________________________Relationship: ______________________________
Alberta Personal Health Care Number (optional): ____________________________________

MEDICAL INFORMATION

1. Medical intervention which is being requested of the school staff:
_____ Medication Administration
_____ Medical Treatment (Please describe):____

____

2. Purpose of Medication/Medical Treatment: ____

3. Student is able to self-administer medication/medical treatment: Yes _______No ______
If yes, please indicate if and how the student is to carry/access medication (i.e. inhaler, epipen):
If no, please provide specific instructions:

____

____

____

4. Special Storage Instructions: ____

5. Emergency procedure in event of reaction: ____

6. Designated medical facility/hospital in the event of an emergency: _______________________

Physician Name: _____________________ Physician's Telephone: ____________________

7. Name of Pharmacy: ___________________ Telephone: ______________________________

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 medication/medical treatment.

- The physician prescribed medication and specific medical supplies are to be provided in the original container. The medication will have the pharmacy label attached.

- The dose schedule of medication has been planned such that a minimum number of doses will be given at school.

- The parent or legal guardian is to provide instruction on the proper administration of medication/medical treatment in cooperation with and under the direct supervision of a physician/medical professional familiar with the medication/medical treatment.

- The parent or legal guardian is to repeat and update the medication/medical treatment instruction should:

    - the student's medical condition change,
    - the medication/medical treatment requirements change,
    - the school staff member assisting the student with the medication/medical treatment change and/or,
    - the school principal requests a review or update on the medication/medical treatment instruction.

The parent/legal guardian understands that for specific medical situations, school policy will require assisting staff to summon medical practitioners or paramedics.

I request that the school staff administer/monitor my child's medication in accordance with the Student Focused Medication Management Plan.

I am prepared to arrange specific instruction for the administration of medication/medical treatment at (location) ________________on (date)____________________ to (Name of School Principal) ___________________________.

.
This information has been provided in confidence to assist in responding appropriately to the medical needs of my child.

____________________________________ ______________________________

(Parent/Guardian Signature) Year Month Day

ADMINISTRATION OF MEDICATION/MEDICAL TREATMENT RELEASE FORM

The undersigned, ____________________________, being the legal parent/legal guardian of ____, a student of the Buffalo Trail Public Schools, do hereby request and authorize personnel employed by the Division to provide/monitor necessary medication/medical treatment to the said student, and for so doing, this will serve as a release and indemnification of and from any action or interaction of any personnel of the Division associated with the administration of medication/medical treatment to the said student. Further, the undersigned parent/legal guardian recognizes and acknowledges that the personnel employed by the Division who may, as a result of this request, be administering medication/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 and to provide copy to parent/guardian.

To: Parent or Guardian

Re: **Your Request for Medication to be Given at School**

Many students require physician prescribed medication to be taken during school hours. To ensure the safe management of medication, each student should have his/her own **Student Focused Medication Management Plan** developed during a meeting with school staff.

To prepare for this meeting, please:

1. Read the attached information about the philosophy, definitions and goals of the **Student Focused Medication Management Plan.**

2. Complete and sign the **Administration of Medication/Medical Treatment To Student Approval Form** and the **Administration of Medication/Medical Treatment Release Form.**
3. Complete the parent's section of the **Student Focused Medication Management (SFMM) Plan** using information from the pharmacy label on your child's medication and the information sheet provided by your pharmacist.

If you have questions or require assistance, a community health nurse is available to help you. Please call the school for her name and number.

____

Principal, ____________________________
(School)

STUDENT FOCUSED MEDICATION MANAGEMENT (SFMM) PLAN

Philosophy

The guiding principle for the management of medication in schools is the belief that the safe management of medication with school-aged children should:

- promote self management,
- be developmentally appropriate,
- lead to maximized learning potential for the student,
- provide the framework to support school staff in their medication management role and, lead to medication compliance

All physician prescribed medications given at school should be managed in accordance with the guidelines for Student Focused Medication Management (SFMM). The guidelines apply to short term and long-term medication administration or monitoring. These guidelines do not apply to over the counter or herbal medications.

The purpose of setting standards within the SFMM Plan is to clearly outline the roles of each of the partners (parents, school staff, students and community health nurse). Each member's role is important to ensure student safety and well being. Parents are the link between their child, the physician, and the school. Parents need to ensure that accurate, complete information about their child's medication management is shared with all partners. School staff are critical to implementing the SFMM Plan. The student is also a partner in managing their medication needs within the school. The student's role can vary from 'being aware of the need for medication' to 'self-managing their medication with adult supervision' depending on their age and developmental stage. The community health nurse is a support who is available upon request. The nurse can assist with the development and implementation of a SFMM Plan and can act as a resource to parents, students and school staff.

The SFMM Plan is designed to be flexible to suit a variety of situations. All students requiring medication management for physician prescribed medications should have a SFMM Plan to ensure that their medication information is complete and accurate.

A copy of the Plan should be provided to the parent. The SFMM Plan should be updated on a regular basis, minimally, on an annual basis.

Definitions

The safe administration of medication depends upon clear and open communication between the partners. Having a common set of definitions ensures a common understanding.

Student Focused Medication Management Plan	Clear details of physician prescribed medications to be given or monitored for a specific student are written out and agreed upon by the parent and school staff.
Medication Management	Administration and monitoring of physician prescribed medication
Administration of Medication	Direct involvement in preparing and giving medication
Monitoring of Medication	Observing a student who is self-medicating and/or ensuring medication is taken
Therapeutic Effect of Medication	Desired outcome of taking medication
Side Effect of Medication	Undesirable effect of medication

Goals of the Student Focused Medication Management Plan

Establish a process that will increase the skills and confidence of school personnel managing physician prescribed medications required for the well-being of the student and to enhance student learning.

Address concerns regarding the safe and consistent management of physician prescribed medications in the school setting.

Involve the student in self-medication and increase their sense of control regarding their personal health and well-being.

Provide an environment of confidentiality that enables and enhances the student's ability to manage their health condition.

Student Focused Medication Management Plan

This plan is intended for physician prescribed medications only.

Student Name: ______________
(Last / First)
Date of Birth:_________________
(Day/Month/Year) ☐Male ☐Female

		Medication #1 ☐ Administer ☐ Monitor	Medication #2 ☐ Administer ☐ Monitor	Medication #3 ☐ Administer ☐ Monitor	Medication #4 ☐ Administer ☐ Monitor
	Received medication in original container	☐ Yes	☐ Yes	☐ Yes	☐ Yes
COMPLETED BY PARENT	Medication Information sheets provided	☐ Yes	☐ Yes	☐ Yes	☐ Yes
	Name of medication				
	Desired effect(s) of medication				
	Possible side effects(s) of medication				
	Plan of action in response to side effect(s) event				
	Dose of medication				
	Route of administration				
	Time(s) medication to be given at school				
	Start date of medication				
	Finish or review date of medication				
Completed During Meeting	Location of medication administration/monitoring				
	Name of staff person to administer / monitor medication				
	Name of alternative staff to administer / monitor medication				
	Special Instructions (Please attach pharmacy printout)				

Parent Name: ___________________________ Signature: _________________________ Date: ___________

Principal Name: _________________________ Signature: _________________________ Date: __________

Other: _________________________________ Signature: _________________________ Date: __________

Student Focused Medication Management Plan

This plan is intended for physician prescribed medications only.

Student Name: ____Doe, John__________
(Last / First)
Date of Birth:___29/01/04_____ ✓Male ☐Female
(Day/Month/Year)

		Medication #1 ✓ Administer ☐ Monitor	Medication #2 ☐ Administer ✓ Monitor	Medication #3 ☐ Administer ☐ Monitor	Medication #4 ☐ Administer ☐ Monitor
	Received medication in original container	✓ Yes	✓ Yes	☐ Yes	☐ Yes
COMPLETED BY PARENT	Medication Information sheets provided	✓ Yes	✓ Yes	☐ Yes	☐ Yes
	Name of medication	Ritalin Methylphenedat	Ventolin		
	Desired effect(s) of medication	Focused Calm	Ability to Breathe normally		
	Possible side effects(s) of medication	Vomiting Tremors Convulsions	Normal side effects Tremors Rapid heart rate		
	Plan of action in response to side effect(s) event	Call parent Convulsions: call 911 and parent	Call parent		
	Dose of medication	5 mgm X 3 daily	2 puffs		
	Route of administration	Mouth	Inhaler		
	Time(s) medication to be given at school	30 min. before lunch	Prior to vigorous activity with symptoms		
	Start date of medication	Sept. 17, 2003	Sept. 17, 2003		
	Finish or review date of medication	January, 2004	As needed or indicated by parent		
Completed During Meeting	Location of medication administration/monitoring	Locked in cupboard in Room 11	Fanny Pack		
	Name of staff person to administer / monitor medication	Mary Jones, Secretary	Self Administered & classroom teacher to monitor		
	Name of alternative staff to administer / monitor medication	Lori Diamond, Home Rm teacher	T.A. in classroom to monitor		
	Special Instructions (Please attach pharmacy printout)	None	None		

Parent Name: __Jane Doe______ Signature: ___*Jane Doe*_________________ Date: _Sept 10. 2003_______
Principal Name: __Joan Smith_______ Signature: ______*Joan Smith*________ Date: _Sept 10, 2003_______
Other: ______________________________ Signature: _____________________ Date: __________________

Buffalo Trail Public Schools

203.1AP Exhibit 6

STUDENT FOCUSED MEDICATION MANAGEMENT RECORD

Student Name:_________________________ Date of Birth: ______________School: ______________________Grade: _______
(year/month/day)

Please initial under the appropriate date for each medication administration. If any deviations or side effects, please describe on back of this page.

	Month:												**Year:**											
Medication	**Dose**	**Time**	**Day**																					

All persons who make one or more administration(s) during the month must sign and initial in a space below:

Print Name: ________________________ Signature: ______________________________ Initials: _________

Print Name: ________________________ Signature: ______________________________ Initials: _________

Print Name: ________________________ Signature: ______________________________ Initials: _________

Print Name: ________________________ Signature: ______________________________ Initials: _________

STUDENT FOCUSED MEDICATION MANAGEMENT RECORD

Student Name:__Doe, John_________ Date of Birth: ___1993/01/06____School: _______________________Grade: ___5____
(year/month/day)

Please initial under the appropriate date for each medication administration. If any deviations or side effects, please describe on back of this page.

	Month: September										**Year:** 2003													
Medication	**Dose**	**Time**	**Day** 17	18	19	20	21	24	25	26	27	28												
Ritalin	**5 mgm**	**Morning recess**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**												
Ritalin	**5 mgm**	**Lunch**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**												
Ritalin	**5 mgm**	**Afternoon recess**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**	**JS**												

All persons who make one or more administration(s) during the month must sign and initial in a space below:

Print Name: ____Joan Smith___________ Signature: ____*Joan Smith*_________________ Initials: ___JS____

Print Name: _________________________ Signature: _______________________________ Initials: _________

Print Name: _________________________ Signature: _______________________________ Initials: _________

Print Name: _________________________ Signature: _______________________________ Initials: _________

ASTHMA ALERT

Daily Asthma Management

Asthma can be controlled by avoidance of triggers and proper use of medication. In spite of this, sudden attacks may occur; therefore, the child (or an accompanying) must keep his / her medication with them at all times.

Identify triggers (check all that apply to the child)

☐ Exercise	☐ Animal	☐ Pollen
☐ Respiratory infection	☐ Mold	☐ Change in temperature
☐ Perfume / cologne / aftershave	☐ Chalk dust	☐ Food ___________________
☐ Strong odor or fume	☐ Carpet in room	☐ Other __________________

Environment

List environmental control measures the child requires to prevent an asthma attack.

____

____

List activity guidelines the child requires to prevent an asthma attack.

____

____

Symptoms of Asthma

All individuals with asthma are unique. Children with asthma may exhibit one or several of the above signs. Some children may not appear to be in distress. All symptoms are of equal importance. Symptoms of asthma include:

- Laboured breathing
- Chest tightness
- Wheezing
- Cough
- Cough with phlegm

The child's specific symptoms are:

____

____

Parent Comments / Special Instructions

____

____

Buffalo Trail Public Schools

ASTHMA ALERT

ID Photo

Last Name:____________First Name:___________________Initial ________

DOB: _____ /______ /_____ Health Care No.: __________________________

(Day / Month / Year)

Room: _______________________Grade: __________________

Signs of worsening asthma are:

- Has a hard time breathing with:
- Chest and neck pulled in with breathing
- Is hunched over
- Struggles to breath
- Can't say a complete sentence in one breath
- Trouble walking or talking
- Becomes quiet or withdrawn
- Lips or fingernails are gray or blue
- Cough, wheeze or rapid breathing

This child's indicators of worsening asthma are: ____

Emergency Action Plan

Act immediately and do not leave child alone.

Stay calm, reassure the child.

Listen to the child. Believe what the child is telling you.

1. Remove the child from the environmental triggers.
2. Have the child stop all physical activity.
3. Give the prescribed medications as below.

Drug Name	Dosage (amount)	When to Use
_________________	__________________	_____________________
_________________	___________________	_____________________

4. Call 911 if ____
5. Notify the parents / guardians.

Emergency Contacts

Mother / Guardian ________________ Phone (H)________________ Phone (W) __________________
Father / Guardian _________________Phone (H) _________________Phone (W) _________________
Other _________________________ Relationship ______________Phone (Day)________________

I consent to the Emergency Action Plan and administration of the prescribed medications as outlined above.

___________________________________ ___________________________ ______________

Name of Parent / Guardian (Please print) Signature of Parent / Guardian Date

LIFE THREATENING ALLERGY ALERT

Anaphylaxis Information

Anaphylaxis is a severe allergic reaction. **Prompt treatment is absolutely critical!** Therefore, the child (or an accompanying adult) must keep his / her medication with them at all times.

Even if you are uncertain whether the child is having an anaphylactic reaction, administer the prescribed medication (see Emergency Action Plan on reverse side).

Adrenaline may cause some shaking and an increased heart rate. Whenever adrenaline is administered, call 911. The effects of the adrenaline can wear off and the reaction can continue. Tell the operator that an allergic reaction has occurred and that adrenaline has been administered.

Contact the parents or their emergency alternates as soon as possible.

Daily Allergy Management

Identify allergens (check all that apply to the child)

☐Insect bite/sting	☐ Dust	☐ Carpet in room
☐Mold	☐ Strong odor or fume	☐ Chalk dust
☐Animal	☐ Perfume / cologne / aftershave	☐ Other __________
☐Pollen ____________________	☐ Foods	

____

Environment

1. Ensure that staff are aware of a child with a severe allergy.
2. Ensure that staff know the location of the medication(s).
3. A child with a severe allergy may require closer monitoring (i.e. in a lunchroom where food exchanges take place or when exposed to insects / animals).
4. List environmental control measures or restrictions the child requires to prevent an allergic/ anaphylactic reaction.

____
____
____

Parent Comments / Special Instructions

____
____
____

Buffalo Trail Public Schools

LIFE THREATENING ALLERGY ALERT

ID Photo

Last Name:___________________First Name:____________Initial: ______

DOB: _______/_____/_______ Health Care No.: ______________________
(Day / Month / Year)

Room: ______________________ Grade: _____________________

This child has a life threatening anaphylactic allergy reaction to:

__________________	☐ Taste	☐ Touch	☐ Smell
__________________	☐ Taste	☐ Touch	☐ Smell
__________________	☐ Taste	☐ Touch	☐ Smell

Common signs of an anaphylactic reaction:

- Flushing
- Tingling of lips and mouth
- Itchy eyes, nose, face
- Swelling of eyes and face
- Hives
- Vomiting
- Weakness and dizziness
- Swelling of throat
- Inability to breath
- Loss of consciousness
- Wheezing
- Diarrhea

Emergency Action Plan

Act immediately and **do not** leave child alone.

Listen to the child. Believe what the child is telling you.

1. Give prescribed medications as below.

Drug Name	Instructions
______________________	____
______________________	____

2. Call 911.

3. Notify the parents / guardians.

Emergency Contacts

Mother / Guardian ____________________Phone (H) _____________Phone (W) ________________
Father / Guardian ____________________ Phone (H) _____________ Phone (W) ________________
Other: _____________________________ Relationship: ___________ Phone (Day) _______________

I consent to the Emergency Action Plan and administration of the prescribed medications as outlined above.

____________________________	______________________________	_____________
Name of Parent / Guardian (Please print)	Signature of Parent / Guardian	Date

Date

Dear Parent:

A student who is registered at our school has a severe life-threatening allergy to peanuts and peanut products. Exposure to even a minute amount of the food substance could cause anaphylactic shock and, without immediate emergency medical assistance, loss of consciousness and death. The school has established an emergency plan for the student.

The school has an obligation to establish a safe environment for all students. Therefore, we are requesting that parents avoid including peanuts and peanut products in lunches or snacks. Information concerning School Lunch Ideas is attached, a number of alternatives to peanut butter sandwiches are suggested.

Our objectives are to establish and maintain, to the extent possible,

- Classrooms, attended by the student, which are free of the substances which could place the student at risk of anaphylactic shock;
- School practices which reduce the possibility of exposure to substances which cause anaphylactic shock; and
- Buses which are free of substances which could place an allergic student at risk of anaphylactic shock.

A meeting for parents has been scheduled for _______________ at the school. The purposes of the meeting are to share information concerning anaphylactic shock and to seek cooperation from parents in order to reduce the risk of exposure to peanuts and peanut products. If you are unable to attend, please telephone the school for additional information.

Thank you for your assistance with this important matter.

Sincerely,

Principal

Attachment

Buffalo Trail PUBLIC SCHOOLS

SEIZURE OBSERVATION AND RECORD

Name ______________________________ Grade: ________ Date: ___________

Observer: ____________________________ Position: ________ Date: ___________

Before the Seizure

1. Did you see the onset of the seizure? Yes ☐ No ☐
2. Or did someone alert you? Yes ☐ No ☐
3. Where was the student? ____
4. What was he/she doing? ____
5. Did he/she Cry or yell ☐ Fall down ☐ Stare ☐ Other ______________
6. Did he/she notice any of these aruas? Smell ☐ Sound ☐ Visual ☐

   Have strange sensations in the stomach ☐ Other ___________________________

Additional comments ____

During the Seizure

1. Did he/she have convulsions? Yes ☐ No ☐
2. Which parts of the body were involved? __________________________________
3. How long did the seizure last? Minutes ☐ Seconds ☐
4. Did he/she Wander around ☐ Stare ☐ Fall ☐ Pick at clothes/body ☐

   Have mouth movement ☐
5. Did he/she Talk clearly ☐ Mumble ☐ Slur ☐ No speech ☐
6. On which side of the body did the seizure start? Right ☐ Left ☐ Both ☐ Unknown ☐
7. Did he/she drool during the seizure? A little ☐ A lot ☐ None ☐

   Excess swallowing ☐
8. What was his/her level of consciousness? Unconscious ☐ Dazed ☐ Alert ☐
9. Did he/she have a loss of bodily control? Bladder ☐ Bowel ☐ Both ☐ Neither ☐
10. Watch his/her:

    a) Breathing Impaired ☐ Absent ☐

    b) Head or face Twitching or grimacing ☐ Up or down ☐

    c) Eyes rolling To the right and left ☐ Upwards ☐ Downwards ☐

    d) Arms and legs Rigid or jerking ☐ Equal & rhythmic ☐ Extended & flexing ☐

    e) Skin tone Pale ☐ Blue/grey ☐ Cool ☐ Warm ☐ Clammy ☐

Additional comments: ____

After the Seizure

1. Was the student injured? If yes, please describe

____

____

2. Does he/she have a headache? Yes ☐ No ☐
3. Can he/she recall the seizure? Yes ☐ No ☐
4. Does he/she appear: Alert ☐ Drowsy ☐ Confused ☐
5. Is there muscle tiredness or weakness specific to one site? Yes ☐ No ☐

   If yes, where? ____
6. Does he/she feel Sleepy☐ Weak ☐
7. If sleepy, how long did he/she sleep post seizure? ___________________________________

Additional comments

____

____