Chinook's Edge School Division No. 73 - Administrative Procedures

EX 2 – 09.3 Medical Information Form

Related Procedure: AP 2 – 09 Field Trips and Excursions

MEDICAL INFORMATION FORM

Please provide the following information in order for school supervisors to properly plan and care for your child's needs.

Student Name: _____ **Date:** _____

Medical History:

1. Is the student on any medications? Please list:
   _____

2. Does the student have any allergies? Yes ___ No ___
   If so, what is he/she allergic to:_____
   How severe is the reaction? _____
   What medications make it better? _____
   Please describe when and details concerning last allergic reaction _____
   _____

3. Does the student possess any dietary restrictions? eg. vegetarianism, lactose intolerant, gluten/wheat free, etc. _____
   _____

4. Does the student have any of the following conditions:
   Asthma – Yes ____ No ____, Does he/she carry an inhaler? Yes ___ No ___
   Other respiratory problems – Yes ____ No ____, _____
   Diabetes – Yes ___ No ___, how is it cared for? _____
   Hyper or hypoglycemia - _____
   Heart conditions – Yes ___ No ___, _____
   Intestinal problems – Yes ___ No ___, _____
   Stomach ulcers – Yes ___ No ___, _____
   Epilepsy or other neurological disorders – Yes ___ No ___, _____
   Iron deficiency – Yes ___ No ___, _____
   Low immune system – Yes ___ No ___, _____
   Mono or chronic fatigue – Yes ___ No ___, _____

5. Are there any recent injuries to be concerned about (including concussions)? If yes, please describe
   _____
   _____

6. Is there any other physical, psychological, emotional, behavioural or situational issue that may affect the student's ability to complete the proposed activity? _____
   _____

_____	_____	_____
Date (Year/Month/Day)	**Parent/Guardian Name Printed**	**Parent/Guardian Signature**

Only complete the shaded section of the form if your child requires the medication to be administered during the Field trip.

MEDICATION ADMINISTRATION AND RELEASE FORM

I,_____(parent/guardian's name) parent/guardian of _____ (student's name) permit the medicines outlined below to be administered to my child at the appropriate time and dosage as also detailed below.

I also permit the Lead Teacher or another willing adult supervisor to properly and securely store my child's medication during the off-site activity and place the Field Trip Leader or another willing adult supervisor in charge of maintaining these medicines and back-up medicines for the duration of the trip. However, I am aware that, under extraordinary circumstances, the medicines may become lost, stolen or damaged. In these circumstances, I will not hold the Field Trip Teacher or another willing adult supervisor liable to replace medicines lost.

I understand that neither the Field Trip Leader or another willing adult supervisor have any training in the administering of medication. Neither I nor my child will hold either the Field Trip Leader or another willing adult supervisor who administers medication liable for any results of administering the medication and I and my child acknowledge that the protection afforded by the *Emergency Medical Aid Act* (the Act) shall be available to such person who administers medication to my child and no challenge to the applicability of such Act shall be brought and administering medication by the Field Trip Leader or another willing adult supervisor shall be conclusively deemed to fall within the ambit of the Act.

I am fully aware of these medicines' effects and side effects and understand that risks involved with my child taking them during this off-site activity. Risks could include but are not limited to missed dosage, too much or too little medication given, dosage not given at the right time, dosage not given under proper circumstances (eg. not with food or water) medicines mixed up with other medicines, side effects, interactions with other medicines that are given in an emergency. Taking these medicines will not inhibit, alter or prevent my child's performance during the activity. Instead, not taking these medicines may inhibit, alter or prevent my child's/charge's performance during the activity.

I hereby consent to the following medicines and dosages to be given to my child at the following times of day under these circumstances.

_____	_____	_____
Date (Year/Month/Day)	**Parent/Guardian Name Printed**	**Parent/Guardian Signature**

The personal information requested on this form is collected under the authority of the School Act that mandates the program operations and services offered by Chinook's Edge School Division No. 73 and will be protected under the privacy provisions of the Freedom of Information and Protection of Privacy Act. If you have questions about the collection and use of the information, contact the FOIP Coordinator, Chinook's Edge School Division No. 73, 4904 – 50 Street, Innisfail, Alberta T4G 1W4. Phone 1-800-561-9229 or 403-227-7070.