

MEDICAL STATUS UPDATE / REQUEST FOR MEDICAL TREATMENT Form 316-1

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 please.

When a student has a medical condition that requires that EICS staff members assist with either:

- Administering Medication,
- Monitoring Medication,
- or
- Assisting with some no- medication related Medical Treatment

EICS requests that the details of that treatment or medication are updated and validated every school year.

STUDENT DEMOGRAPHIC / EMERGENCY INFORMATION

Student Name: _____ Date of Birth: _____

School: _____ School Year : _____

911 Address: _____

Parent/Guardian 1: _____

Day Phone: _____ Cell: _____

Parent/Guardian 2: _____

Day Phone: _____ Cell: _____

Emergency Contact 1 Name: _____

Relationship: _____ Day: _____ Cell: _____

Emergency Contact 2 Name: _____

Relationship: _____ Day: _____ Cell: _____

Alberta Personal Health Care Number (optional): _____

Medic Alert Number (if applicable): _____

Physician Name: _____ Physician Phone: _____

Pharmacist Name: _____ Pharmacist Phone: _____

MEDICAL CONDITION INFORMATION

To help maintain up to date records on student medical conditions, please provide a full summary of conditions which currently affect this student. This may include conditions not relevant to the particular treatment being requested, as long as they are relevant to the student’s time at school in general.

Description of Conditions: _____

Triggers: _____

Symptoms/Signs of Onset: _____

Is the condition Life Threatening (please circle Yes or No) Yes No

Is the student able to self-diagnose their condition? (please circle Yes or No) Yes No

NON-MEDICATION BASED TREATMENT REQUEST

If a Non-Medication-based treatment is being requested, please describe it here:

Purpose of Medical Treatment:

Designated medical facility / hospital in the event of an emergency: _____

STUDENT FOCUSED MEDICATION MANAGEMENT PLAN

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

To prepare for this meeting, please read the philosophy statement below and provide details about the different medications which would be involved in the plan. Please note that a maximum of 3 medications can be submitted at once on this form - if there are more medications involved, please submit a second copy of this form.

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 may be requested by parent or school that can assist with the development and implementation of a SFMM Plan and who 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.

***Up to date copies of the SFMM and the student's full Medical Treatment Plan, including all condition information, ongoing precautions and emergency action plans, are available through the PowerSchool Parent Portal.**

STUDENT FOCUSED MEDICATION MANAGEMENT PLAN – PARENT INFORMATION

Please note that all medication must be received in the original container(s).

Student Name:	Medication #1	Medication #2	Medication #3
	<input type="checkbox"/> Administer <input type="checkbox"/> Monitor	<input type="checkbox"/> Administer <input type="checkbox"/> Monitor	<input type="checkbox"/> Administer <input type="checkbox"/> Monitor
Medication name			
Prescription number			
Desired effect(s)			
Possible side effect(s)			
Plan of action in response to side effect(s)			
Dose of medication prescribed daily			
Route of administration			
Time(s) medication to be given at school			
Start date of medication			
Finish or review date of medication			
Expiry date of medication			

STUDENT FOCUSED MEDICATION MANAGEMENT PLAN – OFFICE INFORMATION

Please note that all medication must be received in the original container(s).

Student Name:	Medication #1	Medication #2	Medication #3
	<input type="checkbox"/> Administer <input type="checkbox"/> Monitor	<input type="checkbox"/> Administer <input type="checkbox"/> Monitor	<input type="checkbox"/> Administer <input type="checkbox"/> Monitor
Received medication in original container	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Medication Information Sheets provided			
Location of medication administration / monitoring			
Name of staff person to administer / monitor medication			
Name of alternate staff person to administer / monitor medication			
Special Instructions (indicate if pharmacy printout attached)			

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 hereby affirm that I am the legal parent/guardian of this student and I request and authorize personnel employed by Elk Island Catholic Separate School Division to provide/monitor necessary medication/medical treatment to said student in accordance with the information provided above, 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.

I acknowledge that this information has been provided in confidence to assist in responding appropriately to the medical needs of my child. Further, I recognize and acknowledge that 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.

Parent/Guardian 1 Signature: _____

Parent/Guardian 2 Signature: _____