



TF002

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 and then shredded. Contact person concerning this collection is the school principal.

LIFE-THREATENING MANAGEMENT AND PREVENTION PLAN

STUDENT INFORMATION *(to be completed by Parent/s)*

Bus Route _____

Name of Student _____

Birth Date _____

School Name _____

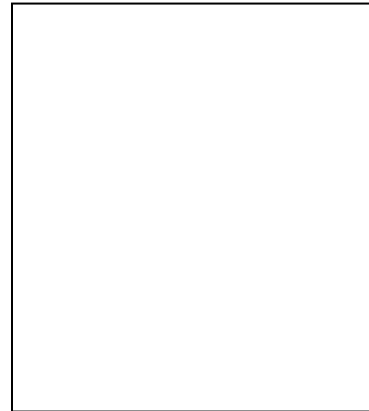
Home Address _____

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 Concern _____

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 _____

PARENT/GUARDIAN COMMITMENTS

At School

Complete LIFE-THREATENING MANAGEMENT AND PREVENTION PLAN in conjunction with Principal or Designate.

Provide appropriate medication and consent for administration.

Provide up-to-date photos if necessary.

On Excursions

Check appropriate box on excursion form and provide special instructions.

EMERGENCY ACTION PLAN *(to be completed by parents with school personnel input as necessary)*

List steps to be taken:

PARENT AGREEMENT

I, _____, acknowledge my participation in the development of the preceding Life-threatening Management and Prevention Plan and agree to execute reliably the parent commitments listed within them. I give my consent for the staff _____ School to execute 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 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

Date _____

Principal will direct copies to:

Parent

Teacher(s)

Bus Operators

Posted as Appropriate

Service de transport de Wellington – Dufferin Student Transportation Services