PREVALENT MEDICAL CONDITION — CHRONIC AND HIGH RISK MEDICAL CONDITIONS PLAN OF CARE

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ HR _____ Teacher(s) _____

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

MEDICAL INFORMATION – CHRONIC/HIGH RISK MEDICAL CONDITION (to be completed by Family Physician)

Chronic/High Risk Medical Condition:			
Possible Signs of Acute Symptoms:			
Recommended Response:			
Medication:		Dosage:	
Medication:		Dosage:	
Additional Instructions or Information:			
Name of Physician: (Please Print)		Physician's Telephone:	
Signature of Physician:		Date:	

STUDENT INFORMATION: (to be completed by Parent(s)/Legal Guardian(s) – if not a minor)			
Name of Student:			
Birth Date: (dd/mm/yy)		Medical Alert I.D.#	

PARENT/GUARDIAN COMMITMENTS

At School

- ☐ Complete Student Health Support Plan (Plan of Care) in conjunction with Principal or designate.
- ☐ Provide appropriate medication/supplies and consent for administration.
- ☐ Provide up-to-date photos if necessary.

On Field Trip/Excursion

- ☐ Fill out appropriate area on Field Trip/Excursion Information form and provide special instructions.

EMERGENCY ACTION PLAN

(to be completed by Parent(s)/Legal Guardian(s)/Student (if not a minor) with school personnel input as necessary)

IN-SCHOOL PLAN OF CARE / DAILY MANAGEMENT PLAN

(to be completed by Parent(s)/Legal Guardian(s)/Student (if not a minor) with school personnel input as necessary)

STUDENT INFORMATION: (to be completed by Parent(s)/Legal Guardian(s) – if not a minor)			
Name of Student:			
Birth Date: (dd/mm/yy)		Medical Alert I.D.#	

PARENT / GUARDIAN AGREEMENT

I, _____acknowledge my participation in the development of the preceding Student Health Support Plan and agree to execute reliably the parent/guardian commitments listed within them.

I give my consent for the staff of _____ School to execute the Plan. I understand that this Plan will be reviewed annually (prior to the beginning of each school year) and I will update the school if circumstances change before the 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 Windsor-Essex Catholic District School Board and its employees of responsibility for any adverse reactions resulting from administration of the medication.

I/We the parents/guardians of _____ give permission for this individual Student Health Support Plan to be displayed in the school office, staff room, homeroom, school bus, cafeteria, food service office, and for other parents and concerned individuals to be advised of our child's condition.

Parent/Guardian/Student (if not minor) Signature:	
Date:	

School Principal will direct copies to: Parent, Teacher(s), Student's Ontario Student Record, General Manager of Student Transportation, other staff working directly with the student on a daily basis, and post as appropriate.