ATTACHMENT 2

Horizon School Division
Policy JFCH
Medical Management Plan
Medical Conditions and Disabilities Information

(To Be Completed by Parent/Legal Guardian or Independent Student)

This plan is for the 20_____/20___ School Year

STUDENT'S LEGAL LAST NAME:	**STUDENT'S LEGAL FIRST NAME:**	**STUDENT'S LEGAL MIDDLE NAME:**
STUDENT ALIAS (Student goes by):		
AB ED Student ID Number:		
Grade:	**Age:**	**Date of Birth:**
Name of Medical Condition/Health Concern: (please specify if any allergies are life threatening)		
Date of Last Review of Plan:		
Homeroom Teacher:		**Room:**
Parent/Guardian Name: **Phone (Home):**	**Phone (Work):**	**Phone (Cell):** **Address:**
Parent/Guardian Name: **Phone (Home):**	**Phone (Work):**	**Phone (Cell):** **Address:**
Name(s) and contact phone numbers of Physician(s)/Health Care Provider(s):		
Emergency Response: Emergency Contact #1: _____ (Name/Relationship) Phone (Home): _____ Phone (Cell) _____ Phone (Cell)_____ Emergency Contact #2: _____ (Name/Relationship) Phone (Home): _____ Phone (Cell) _____ Phone (Cell)_____		

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Medical Management Plan (Continued)

Medical Conditions and Disabilities Information

STUDENT'S LEGAL LAST NAME:	**STUDENT'S LEGAL FIRST NAME:**	**STUDENT'S LEGAL MIDDLE NAME:**

Describe the medical condition(s) that require attention/assistance, include current treatment, and signs or situations that indicate an emergency response is needed. If condition is an allergy, please specify what the student is allergic to and whether the allergies are life threatening

List the steps to take in the event of an emergency related to this condition (include treatment other than medication which is appropriate when symptoms appear):

SYMPTOMS:

List symptoms of the condition that this student is experiencing or may experience and strategies for managing these symptoms:

MONITORING:

List signs or symptoms that may indicate the condition is not under control or that medication needs to be adjusted. Identify specific steps that the student or teacher should take to monitor this condition:

Horizon School Division

Medical Management Plan (Continued)

Medical Conditions and Disabilities Information

STUDENT'S LEGAL LAST NAME:	**STUDENT'S LEGAL FIRST NAME:**	**STUDENT'S LEGAL MIDDLE NAME:**

MEDICATIONS:

Provide copies of any prescriptions and/or information about medications this student is taking, including dosage and location for any medications to be given at school. List any current or possible side effects of this/these medication(s):

Name of Medication:

Prescribed Dosage Amount:

Frequency of Dosage (When to Use):

Possible Side Effects (if any):

Medication Start Date: **Medication Completion Date:**

Location of Medication at school:

***NOTE: Medications administered at school MUST be* contained within the original prescription container, complete with current label.**

SPECIAL INSTRUCTIONS FOR STORAGE OF MEDICINE and/or EPINEPHRINE auto injectors:

THIS MEDICATION IS TO BE (Check one): NOTE: A staff member may be preauthorized to administer or supervise student administration of medication in response to an anaphylactic reaction, and may do so, if (a) the information maintained in this plan remains current, and consent has been given by the parent or student, as applicable.

- ☐ Self-administered by the student or under the supervision of a staff member
- ☐ Administered to the student under the direction of a staff member
- ☐ Administered by the following staff member: _____
- ☐ Used only when the following symptoms appear (describe below):

TRIGGERS AND RESTRICTIONS:

List any foods, activities, situations, etc. that this student should avoid:

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Medical Management Plan (Continued) Medical
Conditions and Disabilities Information

STUDENT'S LEGAL LAST NAME:	**STUDENT'S LEGAL FIRST NAME:**	**STUDENT'S LEGAL MIDDLE NAME:**

ACCOMMODATIONS AND SPECIAL CONSIDERATIONS
List any adaptations or strategies that will assist this student in participating as fully as possible:

List strategies that reduce the risk of exposure to anaphylactic causative agents in classrooms and school common areas:

Risk	Strategies to Avoid Allergen	Who is responsible

COMMUNICATION PLAN
For the dissemination of information on life-threatening allergies to all parents, students and employees

Independent Student Signature (if applicable)	**Independent Student Name (PLEASE PRINT) (if applicable)**	**Date**
Parent/Guardian Signature	**Parent/Guardian Name (PLEASE PRINT)**	**Date**
Physician/Health Care Provider Signature	**Physician/Health Care Provider Name (PLEASE PRINT)**	**Date**
Principal Signature	**Principal Name (PLEASE PRINT)**	**Date**

Personal information is collected under the authority of the *Education Act* and *Alberta's Freedom of Information and Protection of Privacy Act (FOIP).* This information will be used to respond to the identified medical need of the student named above. It will be treated in accordance with the privacy protection provisions of the FOIP Act.