Critical Medical Alert Form

School Year 2014 2015

*To be completed for **HIGH RISK** medical conditions **ONLY**. Do not complete for regular seasonal allergies or minor conditions which are not emergency 911 status. The intent of this form is for school personnel to immediately identify high risk medical issues prior to updating information provided on the Student Information Verification Form.*

To be completed by Parent/Guardian

Name of Student:	**Grade:**	**Date of Birth:**

Home Address:	**Home Telephone:**

Dangerous, Life-Threatening Conditions:

☐ Anaphylactic Allergies Triggers (please specify) _____

☐ EpiPen (carried by student) ☐ 2nd EpiPen (kept in Main Office)

☐ Asthmatic Triggers (please specify) _____

☐ Inhaler (carried by student) ☐ 2nd Inhaler (kept in Main Office)

☐ Diabetic ☐ Epileptic ☐ Hemophiliac ☐ Heart Condition ☐ Seizures

☐ Other

Please specify _____

Recommended Immediate Emergency Response:

Medication(s) Prescribed:

Parent/Guardian:	**1st Contact Phone Number:**	**2nd Contact Phone Number:**
Parent/Guardian:	**1st Contact Phone Number:**	**2nd Contact Phone Number:**
Emergency Contact:	**Relationship:**	**Contact Phone Number:**

Authorization for Administration of EpiPen Injection

In the event that my son/daughter is not capable of self-administration, I hereby authorize and instruct the Principal or his designate(s) to administer epinephrine by injection to my son/daughter, for the purpose of providing temporary emergency response to a perceived life-threatening occurrence which may be seen to result from an allergic reaction.

My signature shall be your good and sufficient authority to administer epinephrine by injection, and recognizing that staff are not medically trained, I shall not hold the person administering the medication, the Waterloo Catholic District School Board or any of its school personnel liable for any action whatsoever which may arise out of the said medication administration, either at this given time, or at any given time in the future.

Dated at _____this _____day of _____, 200__

_____

Signature of Authorizing Parent/Guardian

Personal information on this form is collected under the authority of s. 265(1)(d) of the *Education Act*, and pursuant to sections 28(2) of the *Municipal Freedom of Information and Protection of Privacy Act.* The information collected on this form will be used for providing emergency medical treatment. Any questions regarding the collection of this information should be directed to the principal of the school. This form is kept in the School's Medical Emergency file, the OSR and provided to transportation service as required.

Family Doctor:	**Phone:**
Parent/Guardian Signature:	**Date:**