EX 2 - Medical Safety Plan

Related Procedure: AP 3 – 23 Administering Medication to Students

01. STUDENT PROFILE

Student Name:	**Age:**	**Grade:**
Teacher(s):	**DOB:**	**School:**
Current Health Care Provider(s):		
Students Current Care Team:		
Name:	**Profession:**	
Name:	**Profession:**	
Name:	**Profession:**	
Medical Diagnosis or Condition *(include all relevant diagnosis or conditions)*		

02. CONTACT INFORMATION

Parent/Guardian - Contact Information

Parent/Guardian	Address	Contact Number

Emergency Contact Information

Parent/Guardian	Relationship	Contact Number

MEDICATION

Provide information about medication this student is taking, including the name of the medication, dosage, side-effects and if the

medication will be administered at the school. For students requiring that medication be administered at school, review AP 3-23 Administering Medication to Students and have parents/guardians complete the Administering Medication Permission Form and attach the form to this plan.

03. MEDICAL SUPPORT PLAN (To be completed by a physician)

Symptoms

What are the symptoms of the diagnosis/condition that this student is experiencing or may experience, and strategies/supports for managing these symptoms.

Allergies, Accommodations and Adaptations

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

List any adaptations, accommodations, or strategies that will assist this student in participating as fully as possible.

Emergency Response (This section to be filled out by a physician)

Describe signs or situations that indicates an emergency response is required:

List steps to take in the event of an emergency related to this diagnosis/condition:

The school will call 911 immediately when a medical emergency has occurred

04. ACKNOWLEDGEMENT

▢ Administering Medication Permission Form

I have reviewed and updated the above medical safety plan and I understand that if the diagnosis, treatment or medication changes this plan will need to be reviewed.

Team Member Name	Date	Signature

Physician Consent (This must be signed before the plan can be implemented)

Physician Name	Date	Signature

Parent/Guardian Consent

Parent/Guardian Name	Date	Signature

**Medical Safety Plans need to be updated, reviewed whenever there is a change in the medication or medical safety plan. The school division does not include Goals of Care (green sleeves) as part of the medical safety plan for any student.*