



**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 \_\_\_\_\_

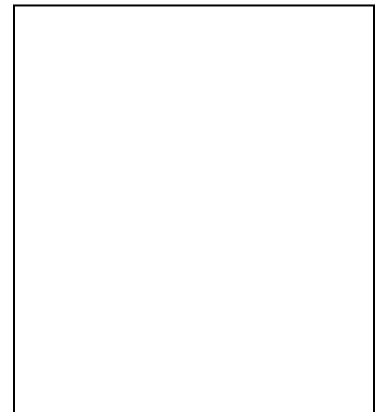
Home Telephone Medic Alert I.D. \_\_\_\_\_

Father's name: \_\_\_\_\_ work No. \_\_\_\_\_

Mother's name: \_\_\_\_\_ work No. \_\_\_\_\_

Guardian's name: \_\_\_\_\_ work No. \_\_\_\_\_

Main contact email . \_\_\_\_\_



**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:

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**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**