Student photo:
(please attach)

2018-2019 EXTREME MEDICAL PLAN OF ACTION FORM

ATTENTION: PARENTS AND MEDICAL PRACTITIONERS
Please complete this form in full and return.
NO MEDICATION MAY BE ADMINISTERED
WITHOUT PROPER WRITTEN CONSENT OUTLINED ON THIS FORM.

EXTREME MEDICAL ILLNESS MANAGEMENT AND INDIVIDUAL PREVENTION PLAN

TO BE COMPLETED BY PARENTS AND MEDICAL PRACTITIONERS

(TO BE POSTED IN CONJUCTION WITH EMERGENCY / MEDICAL / ALLERGY FORM)

TO BE COMPLETED BY PARENT

Name of Student: ____
Date of Birth: ____
Medic Alert #: ____
Name of Father: ____
Bus. #: ______________________ Cell #: _________________________________
Name of Mother: ____
Bus. #: ______________________ Cell #: _________________________________
Emergency Contact (if parents cannot be reached):
Name_______________________________ Phone # ________________________
Health Card #: (optional) ____
Parent Signature: ____
Program Director Signature: ____

(IF REQURED) Date of training / demonstration at Adath Israel Nursery School___________
Parent Initials ___________ Program Director's Initials________________
Parents: Please advise us in writing of any changes to the individual medical plan and treatment of your child.

TO BE COMPLETED BY LICENSED MEDICAL PRACTITIONER

Description if Medical Issue:
____

Monitoring and Avoidance Strategies:
____

Signs and Symptoms of the Condition:
____

Recommended Response:
____

Medication: _______________Dosage and Frequency: ____________________
Expiry Date on Medication:____
Please note that we suggest 2 epi-pens be left at school.
How to Administer Medication:
____

Storage of Medication:
____

(i.e. refrigerator, with child, in cupboard – location of epi-pen MUST BE LISTED)
Has your child ever been hospitalized for the condition? If so, when?
____

Have you ever had to call 911 for the condition? If so, when?
____

Have you ever had to administer an Epi-pen? If so, when?
____

Has you child ever been treated with steroids for asthma? If so, when?
____

Does your child carry his-her own medication? YES NO
If you have answered yes to the above question, WE MUST HAVE WRITTEN CONSENT FROM YOUR CHILD'S PHYSICIAN. Has your child been trained by your physician to address this responsibility?
Date of training:______________
Name of Physician:
____

Telephone #:
____

Date:
____

In the event of an emergency, I authorize the Adath Israel Nursery School staff to administer the designated medication and obtain medical assistance. I agree to assume responsibility for all cost associated with medical treatment and absolve Adath Israel Nursery School staff of responsibility for any adverse reaction resulting from administration of the medication.

Parent Signature:____
Date:_______________________