Calgary Board of Education

Student Health Plan

The Student Health Plan is supported by Administrative Regulation 6002 – Student Health Services.

This form must be:

- completed if a physical or medical condition may affect the student's attendance at school;
- completed if medication is to be taken at school; and
- reviewed and updated annually or sooner if there is a change in the student's health concern or school registration.

Student Name: _____ **School Year:** _____
(Last Name, First Name, Initial) (yyyy-yyyy)

Birth Date: _____ **Home Room:** _____ **Grade:** _____
(dd-mmm-yyyy)

Section 1 – Health Concern or Medical Condition

Describe the health concern or medical condition:

Section 2 – Medication Management

a) Medical Information – identify name, dosage, frequency and timing of administration, storage requirements

b) Potential side effects of medication

Section 2 – Medication Management continued

c) Response to side effects

d) Responsibilities –outline who does what and when

Section 3 – Communication

How and when will parents/guardians be contacted and under what conditions?

Section 4 – Parent (s) / Legal Guardian Contact Information

Name	Address with Postal Code	Phone(s)	Email

Section 5 - Signatures

Acknowledgement and Waiver by Parent or Independent student

1. Primary responsibility for the administration of medication rests with the student and the student's parents.
2. If granted, approval of this request is valid only for the school and school year in which it is submitted.
3. Any change in the student's medical condition or medication is to be brought to the attention of the principal promptly.
4. Action taken by staff will be limited to what is possible in a school setting and to what can be done by persons untrained in medical procedures.
5. Administration of medication through an epinephrine auto-injector will be provided in emergencies related to anaphylactic shock.
6. Parents are responsible for keeping contact information, including emergency contacts, current and up to date.

Name: _____ **Date:** _____
(Last Name, First Name) (dd-mmm-yyyy)

Signature: _____

Principal approval signature

Name: _____ **Date:** _____
(Last Name, First Name) (dd-mmm-yyyy)

Signature: _____

Authorization for Collection of Personal Information

Personal information is collected under the authority of the *Education Act* and *the Freedom of Information and Protection of Privacy Act*. This information will be used to respond to the identified medical or physical needs of the student named above. If you have any questions regarding the collection of this information, contact the school principal.