

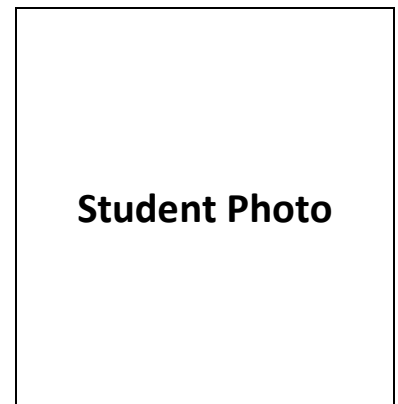
Please Check One:

- Student is a Walker
- Student Rides the Bus

Life Threatening Emergency Medical Form For School and Transportation Use

1. Use of this form is limited **ONLY TO STUDENTS WITH LIFE-THREATENING MEDICAL CONDITIONS** that may require the emergency administration of an epinephrine auto-injector or other emergency medical attention.
2. This form shall contain a clear and recent photograph of the student.
3. Please ensure that this form is filled out completely, legibly and in pen.
4. This form should be updated yearly and/or as medical information changes.
5. NOTE: Bus companies **do not** provide epinephrine auto-injectors on the school bus/vehicle. It is the responsibility of the parent(s)/guardian(s) to ensure that their child carries an auto-injector if it is required. Bus drivers are trained in administering an auto-injector.

Student Name:	
Parent(s)/Guardian(s):	
Civic Address:	
Primary Emergency Contact #:	
Secondary Contact #:	Alternate #:
School:	Grade:
Bus Company:	Route #:



Life Threatening Medical Condition(s):

<input type="checkbox"/>	Allergy/Anaphylaxis to (specify allergy/allergies):
Auto-injector can be found (Please indicate location of auto-injector on student):	
<input type="checkbox"/>	Asthma (specify type of reliever inhaler):
Inhaler can be found (Please indicate location of inhaler on student):	
<input type="checkbox"/>	Other Medical Condition(s) (please specify condition(s) <u>and</u> location(s) of any support devices):

I/we authorize this "Life Threatening Emergency Medical Form" to be shared with school staff, bus companies, bus drivers and Student Transportation of Eastern Ontario (STEO).

Parent(s)/Guardian(s) Signature
Date

FOR STUDENTS WHO ACCESS TRANSPORTATION, I hereby confirm that the school has received the Life Threatening Emergency Medical Form and that discussions were held with the parent(s)/guardian(s) and the bus company and/or bus driver to review the transportation emergency action plan for the child identified on this form.

Principal's Signature
Date

Copy to:	<input type="checkbox"/> School Office Administrator for Student File
Copy (if applicable) to:	<input type="checkbox"/> Bus Company/Driver <input type="checkbox"/> STEO (Fax: 613-925-0024)

EMERGENCY ACTION PLAN: List steps to be taken in a concise and legible format

Medical Condition – Specific Allergy – Please Check All That Apply

Indications of Severe Allergic Reaction:

- | | |
|------------------------------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Difficulty breathing or swallowing, wheezing, coughing, choking | <input type="checkbox"/> Loss of consciousness/passes out |
| <input type="checkbox"/> Flushed face, hives, swelling or itching lips, tongue, eyes | <input type="checkbox"/> Tightness in throat, mouth, chest |
| <input type="checkbox"/> Dizziness, unsteadiness, sudden fatigue, rapid heartbeat | <input type="checkbox"/> Pale blue skin or lips |
| <input type="checkbox"/> Vomiting, nausea, diarrhea, stomach pains | <input type="checkbox"/> Other (identify): _____ |

Medical Condition – Asthma – Please Check All That Apply

Indications of Severe Asthmatic Reaction:

- | | |
|----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Restlessness, irritability, fatigue, coughing (frequent, dry and regular) | <input type="checkbox"/> Wheezing (can't always hear it) |
| <input type="checkbox"/> Breathlessness (child may talk in one or two word sentences; nostrils flaring with breaths) | <input type="checkbox"/> Breathing quickly |
| <input type="checkbox"/> Neck muscles tighten every time they breathe | <input type="checkbox"/> Constantly rubbing nose or throat |
| <input type="checkbox"/> Lips and nail beds may have a grayish or bluish colour | <input type="checkbox"/> Other: _____ |

Asthma Triggers:

- cold/flu/illness mould dust cold weather strong smells pet dander cigarette smoke
 physical activity/exercise pollen allergies (specify): _____

Medical Condition – Diabetes – Please Check All That Apply

Possible Symptoms of Low Blood Sugar in Diabetics:

- * More likely when activity changes (field trip or track day etc.) or if meal time is missed or schedule changes.
- | | | | |
|------------------------------------|-------------------------------------------|---------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> confusion | <input type="checkbox"/> shakes | <input type="checkbox"/> crying | <input type="checkbox"/> increased heart rate |
| <input type="checkbox"/> trembling | <input type="checkbox"/> hunger | <input type="checkbox"/> feeling low | <input type="checkbox"/> numbness or tingling of tongue or lips |
| <input type="checkbox"/> headache | <input type="checkbox"/> withdrawn, quiet | <input type="checkbox"/> pale | <input type="checkbox"/> nauseated |
| <input type="checkbox"/> sweating | <input type="checkbox"/> weak, drowsy | <input type="checkbox"/> irritable, anxious | |
- * May lead to loss of consciousness (passing out) or seizures

Possible Symptoms of High Blood Sugar in Diabetics:

- * More rare
- | | | |
|-------------------------------------------|----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> increased thirst | <input type="checkbox"/> increased urination | <input type="checkbox"/> feeling unwell |
|-------------------------------------------|----------------------------------------------|-----------------------------------------|

Medical Condition – Epileptic Seizure – Please Check All That Apply

Symptoms of Epileptic Seizures:

- | | |
|-----------------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Staring, apparently not hearing, no movement | <input type="checkbox"/> Jerking of the arms, legs, face |
| <input type="checkbox"/> Twitching | <input type="checkbox"/> Drowsiness or inattention |
| <input type="checkbox"/> Drooling or biting lips, cheeks or tongue | <input type="checkbox"/> May become unconscious |

Instructions for bus driver in the event of an epileptic seizure:

DO NOT put anything in the child's mouth. DO NOT restrain movement. If possible, put something soft under the head for protection. AFTER THE SEIZURE put the child on their side in recovery position. If a seizure lasts longer than 5 minutes, or repeats without full recovery, SEEK MEDICAL ASSISTANCE IMMEDIATELY.