



Holy Ghost School



ACUTE HEALTH CARE FORM

DATE: _____

1. PERSONAL INFORMATION

Name of student _____ Date of Birth _____

Address _____

Home telephone number _____

Health coverage registration numbers: Registration # (6 digits) _____

Child's Personal # (9 digits) _____

Parent/Guardian _____

Phone (Home) _____ (Business) _____

Parent/Guardian _____

Phone (Home) _____ (Business) _____

Prescribing physician _____

Office address _____

Office telephone number _____

Dispensing pharmacy _____

Address _____

Telephone number _____

2. STATEMENT OF NEEDS

Explanation of health care problems, risks, or needs:

3. DESCRIPTION OF INTERVENTIONS:

3.1 ROUTINE MEDICATION ADMINISTRATION:

Name of medication _____

Reason for medication _____

Dosage and method of administration (include time) _____

Start date of medication _____

Stop date of medication (if applicable) _____

First dose administered at home? Yes / No (Circle the appropriate response)

First dose well tolerated by student? Yes / No _____

Storage requirements (if necessary) _____

Description of side effects _____

Response to side effects _____

I will send or deliver a sufficient supply of the medication to the school in the original pharmacist's labelled container. If I am unable to deliver it personally, it will be delivered as follows (name of person authorized, and the time(s) of delivery):

3.2 PREVENTATIVE:

Interventions necessary to avoid health care problems (example: avoidance of products containing peanuts for a child with a life-threatening peanut allergy). _____

3.3 RESPONSES:

Signs of distress include: _____

Detailed description of the appropriate response to de-escalate distress: _____

Signs the situation has escalated to an emergency: _____

Detailed description of appropriate response to emergency: _____

Emergency contacts (listed in order they are to be contacted):

#1 Contact name: _____

Relation to student: _____

Home phone #: _____

Work phone #: _____

#2 Contact name: _____

Relation to student: _____

Home phone #: _____

Work phone #: _____

#3 Contact name: _____

Relation to student: _____

Home phone #: _____

Work phone #: _____

4. AUTHORIZATION

I/We authorize the school to contact the doctor, or the dispensing pharmacist, for further information, and I authorize the doctor and/or pharmacist to release any further information requested by the school.

Signature of Parent / Guardian _____

5. RELEASE DECLARATION

I realize that the staff members who volunteer to assist my child in this way are not medical professionals. In consideration of their assistance, I RELEASE HOLY GHOST SCHOOL, AND ITS OFFICERS AND EMPLOYEES, FROM ANY LIABILITY ARISING FROM THE ADMINISTRATION OF PRESCRIBED MEDICATION TO MY CHILD IN ACCORDANCE WITH THE INSTRUCTIONS SET OUT IN THIS REQUEST.

Date:

Signature of Parent (Guardian)

