LAKEHEAD DISTRICT SCHOOL BOARD

PREVALENT MEDICAL CONDITIONS SAFETY PLAN FOR EXTENDED FIELD TRIP

This form must be read and signed annually by every student who wishes to participate in an Extended Field Trip by the parent or guardian of a participating student. Failure to return this form will result in the student not being able to attend the activity. Parent/Guardians are expected to provide the school with any relevant information or changes throughout the school year.

Student Name:

Ontario Health Card #:

Parent(s)/Guardian(s) Name(s):

Home Phone: Cell Phone:

Emergency Contact Name: Phone Number:

Has the student been diagnosed with any of the following? If YES, please check:

- ☐ Migraine Headaches
- ☐ Fainting Spells
- ☐ Ear, Nose, Throat Infections
- ☐ Urinary Infections
- ☐ Skin Conditions
- ☐ Heart Disorders
- ☐ Asthma
- ☐ Other (please specify):
- ☐ Head or back conditions or injuries (in the past two years):
- ☐ Arthritis or rheumatism, chronic nosebleeds, dizziness, fainting, headaches, dislocated shoulder, hernia, swollen or painful joints, trick or lock knee?
- ☐ Digestion Problems
- ☐ Allergies
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Orthopedic Problems
- ☐ Diabetes

What precautions are required?

What things must the student not do?

If allergies, what type?

Does student carry an EpiPen? ◯ Yes ◯ No

Is a special diet required for medical reasons? ◯ Yes ◯ No
Please specify:

Does your child wear Eyeglasses? ◯ Yes ◯ No Contact Lenses? ◯ Yes ◯ No

Does your child wear a medic alert bracelet, chain, or carry a medical card? ◯ Yes ◯ No
Please specify which:

If yes, what is written on it?

Nature of problem or concern:

Is your child prescribed any medication? ◯ Yes ◯ No

i) Type of medication:

ii) How often administered and by whom?

ii) Side Effects:

iii) Storage of Medication

I acknowledge that in the event that:

a) my child suffers from anaphylactic reactions that they will carry at least two (2) epinephrine injectors on the trip;

b) my child is prescribed medication that they will carry a supply of medication sufficient for the duration of the trip plus an additional 50% supply;

c) in the event that the medication requirements a) and/or b) are not met then they shall not be allowed to attend the trip.

Questions to be addressed in the development of the plan:

a) How does / will the bus/airline/other mode of transportation have the means to deal with the prevalent medical condition?

b) How will appropriate food / restaurants be chosen to address the student's prevalent medical condition?

c) Who will speak to the restaurant manager / food provider to indicate and plan for the student's prevalent medical condition?

d) What is the plan for emergency action:

   a. While travelling to the destination?
   b. While at the destination?
   c. While travelling from the destination?

e) Other than the lead supervisor of the trip, who are the backup supervisors that will be fully aware of this safety plan?

f) Other considerations/ information/ knowledge?

This Prevalent Medical Conditions safety plan specific to the trip to:

_____

on the dates_____ has been developed in collaboration with caregiver.

Date of Contact with Parent/Guardian to develop collaborative safety plan: _____

_____ _____

Parent/Guardian Signature **Field Trip Supervisor Signature**

Date: _____ **Date: _____**

Parents are encouraged to purchase student accident insurance as it is not provided by the Board.

FREEDOM OF INFORMATION

Personal information on the medical information form is collected under the authority of the Education Act, R.S.O. 1980, C.129, S.60, and will be kept in a secure place by the teacher. It will be made available to qualified medical personnel only in the event of an emergency. Questions regarding the collection of this information should be directed

OUT OF PROVINCE/OUT OF COUNTRY MEDICAL INSURANCE COVERAGE

(To be completed for trips out of the province of Ontario)

INSURANCE COMPANY NAME: _____

CONTRACT NUMBER: _____

MEMBER NAME: _____

MEMBER I.D.: _____

I have read the above information and agree that it can be made available to qualified medical personnel, if necessary.

Signature of Parent/Guardian _____

Signature of Student _____

Date: _____