



## 2013-2014 Life Threatening Emergency Medical Form

Please check whether the student is: a walker  or rides a school bus/vehicle

Identify the specific medical condition:

If an allergy, identify the specific allergy:  
(e.g. peanuts, bee stings, eggs, etc.)

\_\_\_\_\_  
\_\_\_\_\_

### Student Information:

School Name \_\_\_\_\_  
Student Name \_\_\_\_\_  
Student No. \_\_\_\_\_ Grade \_\_\_\_\_  
Parent(s)/Guardian(s) \_\_\_\_\_  
Civic Address \_\_\_\_\_  
Home/Cell Phone No. \_\_\_\_\_  
Work Phone No. \_\_\_\_\_

(Please provide photograph.)

### Emergency Plan Information – In case of emergency please contact:

Name of First Contact \_\_\_\_\_ Phone No. \_\_\_\_\_  
Name of Second Contact \_\_\_\_\_ Phone No. \_\_\_\_\_

### Location of Medication/EpiPen (if required):

Not on student:  On student:  Location: \_\_\_\_\_

### Action Emergency Plan (if required please add a 2<sup>nd</sup> page):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Parent(s)/Guardian(s) Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby confirm that discussions were held with the parent(s)/guardian(s) and bus driver to review the **transportation emergency plan** for the child identified on this form.

\_\_\_\_\_  
Principal's Signature \_\_\_\_\_ Date \_\_\_\_\_

Copy to:  School Office Administrator for Student Individual/Plan File  
Copy if Applicable to:  Bus Operator  Bus/Van Driver  STEO (Fax: 613-925-0024)



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## Medical Condition – Allergy

### *Indications of Severe Allergic Reaction:*

- Difficulty breathing or swallowing, wheezing, coughing, choking.
- Flushed face, hives, swelling or itching lips, tongue, eyes.
- Dizziness, unsteadiness, sudden fatigue, rapid heartbeat.
- Vomiting, nausea, diarrhea, stomach pains.
- Loss of consciousness/passes out.
- Tightness in throat, mouth, chest.
- Pale blue skin or lips.
- Other: (please identify) \_\_\_\_\_

## Medical Condition – Asthma

### *Indications of Severe Asthmatic Reaction:*

- Restlessness, irritability, fatigue, coughing (frequent, dry and regular).
- Wheezing (can't always hear it).
- Breathing quickly.
- Obvious discomfort.
- Constantly rubbing nose or throat.
- Breathlessness (child may talk in one or two word sentences); nostrils flaring with breaths.
- Neck muscles tighten every time they breathe.
- Lips and nail beds may have a grayish or bluish colour.
- Other: (please identify) \_\_\_\_\_

## Medical Condition – Diabetes

### *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

### *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 the recovery position.

If a seizure lasts longer than 5 minutes, or repeats without full recovery SEEK MEDICAL ASSISTANCE IMMEDIATELY.

## Medical Condition – Other

*Please list any symptoms (please use a 2<sup>nd</sup> page if required):*
