Circular No: 23/2025-26 Date: 15/09/2025

HEALTH & MEDICAL SAFETY NOTICE

Dear Parent,

Consistent presence in school plays an important role in a child's learning journey. However, true learning can only happen when the child is physically fit. When an unwell student attends school, it not only hampers their own learning but may also put other children at risk of infection.

It has been noticed that some students come to school on examination days despite being unwell and then request to leave early. Please be informed that the school permits *re-tests/ weightage* in genuine medical cases, supported by a registered doctor's certificate.

Parents are requested to keep their ward at home if any of the following are observed:

1. Fever of 100°F or above.
2. Vomiting and/or loose motions, often accompanied by fever or loss of appetite.
3. Severe pain requiring strong medication.
4. Conjunctivitis (red eyes).
5. Unexplained, itchy or spreading rashes.
6. Any communicable disease.

Students should rejoin school **only after the recommended recovery period** and must present a **medical fitness certificate** issued by a registered doctor.

For quick and effective medical support during emergencies, the school needs accurate health records of each student. **Hence, parents of students with any medical history or health condition must fill in the attached Medical Information Form and submit it to the class teacher.**

Important Instructions:

- Students involved in school sports who are suffering from any infectious condition will be allowed to play **only after they submit a Fitness certificate issued by a registered doctor.**
- For minor cases, parents will be contacted to collect the child.
- Parents must **keep emergency contact details updated** and provide an alternate guardian's information in case they are out of station.

We sincerely seek your cooperation in ensuring the wellbeing of all children.

WISHING EVERY VISHWA BHARTIAN GOOD HEALTH!

Encl.: Medical Information Form

Amita Ganjoo
Principal

MEDICAL ALERT FORM

Kindly go through the guidelines provided below attentively. If you require any further explanation, you may get in touch with the school office.

This booklet consists of seven pages as all four medical forms have been compiled together in one place. This has been done to make it more convenient for parents to locate and complete the required forms. It also ensures that the school receives all the necessary information in an organized and systematic manner.

Please fill in only those forms that are relevant to your ward and submit them at the earliest in accordance with the School's Management Policy.

Guidelines:

- Review the details given for each form and identify which one applies to your child.
- Mark the checkbox next to the form(s) that you are required to complete.

CHECKBOX Select all that applies	**FORM NAME**	**DESCRIPTION**	**PAGES**
☐	**Medical Alert Form**	Fill in this form if your ward has any health condition that requires special care or medication during school hours.	2 to 3
☐	**Request for Administration of medication**	Fill out this form only in case your child requires medicines to be given while at school.	4
☐	**Vaccination form (Mandatory for all PS & PP parents to fill**	Use this form only if your child requires an emergency action plan for anaphylaxis.	5 to 6
☐	**General Health form**	Fill in this form only if your child requires a diabetes management plan while at school	7 to 8

The details provided in this form are confidential and are safeguarded under the rules of the **Freedom of Information and Protection of Privacy Act**.

Medical Alert Form		**School Year :**
Last Name :		Photo ID (Parents do not send photo unless requested)
First Name :		
Division :		
Grade :		
Birth Date :		
Care Card #		
Contact Name & Telephone Numbers		

Mother / Guardian Last Name :			Mother / Guardian Last Name :		
Mother / Guardian First Name :			Mother / Guardian First Name :		
Home Phone #		Mother/Guardian's work or Cell #		Mother/Guardian's work or Cell #	
Physician's Name			Telephone		

Indicate what medical condition this has that may require emergency care at school:

Describe the potential problem (include symptoms that might be observed)

Describe the necessary action or intervention to appropriately treat this medica | condition :

Step 1	
Step 2	
Step 3	
Step 4	
Step 5	
Is medication needed?	
Is yes, what medication?	
Prescribing Physician : Phone	
Parents must complete a Request for Administration of Medication Form (section below) if their child needs medication administered at school in case of an emergency. **Note** : No medication will be administered until this section of the medical form is completed Parents need to ensure that this medication does not expire It is the obligation of parents to keep a sufficient supply of any required medication at the school.	

I have read and verified that the above information is correct.

Parent / guardian Last Name Parent / guardian Last Name Date

Copy to:

Student's Dossier File
Nursing Support Care Plan (if necessary)

REQUEST FOR ADMINISTRATION OF MEDICATION FOR:

Complete this section ONLY if your child needs medication administered at school.

☐	If changes occur I will contact the school and provide revised instructions. I am aware I am required to update this information each April.
☐	I request that staff give medication as prescribed on this form to my child in case of an emergency
☐	I agree to supply the medication to the school in the original container with the child's name, prescribing physician's direction for use including dosage.
☐	I am aware that the Doctor and Nurse for the school will be informed of my child's condition and medication; and that the Nurse may contact me as necessary.
☐	I am aware that staff and other personnel working with my child will need to know of my child's condition and of the medication required.

If training is required to administer the medication, please specify,

Training on :			
Trainer's Name		Training Date	
Name of Trained Person 1		Name of Trained Person 2	

Authorization – I agree to (select those that apply) :

☐	Supply the school with medications and up-to-date Epi-pen(s)
☐	Provide the child with a medic alert bracelet and fanny-pack for Epi-pen
☐	Ensure the child knows his/her responsibilities for his / her own safety
☐	Ensure the child will have an Epi-pen on their person (It is strongly recommended that children have Epi-pens on their person at all times)
☐	I understand that my failure to do the above may result in an inability to implement timely emergency procedures for this potential life threatening condition
☐	I authorize the staff of School District No.43 and its agents, including volunteers, to execute the school's commitments as outlined within this plan.
☐	I am aware that the Public Health Nurse for the school will be informed of my child's condition and treatment and that the nurse may contact me as necessary.
☐	I give consent for the identification of the child as a person with _____ (nature of condition / risk).
☐	I understand that this may include the display of pertinent information, including a picture of the child in strategic locations within the school. It is understood that the person for this display is to enable the staff of School District No.43 and its agents to be able to respond to potential emergencies in a timely fashion. It is clearly understood that student confidentiality will be maintained wherever possible.

Parent / Guardian Last Name Parent / Guardian First Name Date

[To be submitted at the time of admission of the student]

Name of the Student . . . . . M/F .... .Class. . . . . .Section.....

Date of Birth . . . . . Blood Group . . . . . .

VACCINATIONS

IMMUNIZATION	RECOMMENDED	RECEIVED	
		YES	NO
BCG	0-1 Month		
Hepatitis B	At Birth		
	1 Month		
	6 Month		
DPT	2 Months		
	3 Months		
	4 Months		
HB	2 Months		
	3 Months		
	4 Months		
Oral Polio	At Births		
	1 Months		
	2 Months		
	3 Months		
	4 Months		
Measles	9 Months		
MMR	16 Months		
DPT+OPV+HIB	18 Months		
Typhoid	2 Years		
Hepatitis A (2 Doses)	2 Years		
Chicken Pox	After age 1 year		
DT – OPA	4½ Year		

BOOSTER DOSES

Typhoid (Every 3 years)	DATE	DATE	DATE
TT (Every 5 years)			
Other Vaccines			

Signature of Father .....Signature of Mother .....

TO BE CERTIFIED BY A REGISTERED DOCTOR

Name of the student .....Class .....Academic Year .....

Date of physical examination.....Height .....Weight.....

B.P..... Pulse ..... Vision (L) ..... (R) .....

Squint..... Conjunctiva..... Cornea.....Ear L..... R.....

CLINICAL EXAMINATION	NORMAL	RECOMMENDATION	REMARKS, IF ANY
Head/Neck			
Abdomen			
Surgery			
Serious Illness			
Nails			
Skin			

Summary of Current Health Condition :

_____

_____

_____

Fit to Participate in all age specific physical activity including Swimming

_____

Fit to participate in age specific physical activity **with precaution**

_____

_____

Should not participate in competitive sport / activities involving a lot of physical activity

_____

Signature of Doctor .....

Name of the Doctor.....

HIGH BLOOD SUGAR SYMPTOMS My child's symptoms at time of HIGH blood sugar reaction are usually :		
☐ Headache	☐ Frequent urge to urinate	☐ Excessive thirst
☐ Drowsiness	☐ Nausea / stomach pain	☐ Dry mouth
☐ Behaviour Change		
Other (please explain)		

HIGH BLOOD SUGAR TREATMENT is

If blood sugar is over , notify parent

The school is not responsible for administering insulin

Authorization – I agree to (select those that apply) :

☐	Provide emergency sugars and snacks for the treatment of low blood sugar
☐	Keep a glucometer and adequate supplies for the monitoring of blood sugar levels for my child and ensure child is aware of sage disposal of sharps and supplies.
☐	If changes occur, I will contact the school and provide revised instructions I am aware I am required to update this information as needed.
☐	I am aware that the Nurse for the school will be informed of my child's condition and treatment and that the Nurse may contact me as necessary
☐	I authorize the staff of school and its agents, including volunteers, to execute the school's commitments as outlined within this place.
☐	I give consent for the identification of the child as a person _____ (nature of condition / risk). I understand that this may include the display of pertinent information, including a picture of the child, in strategic locations within the school. It is understood that the reason for this display is to enable the staff to be able to respond to potential emergencies in a timely fashion. It is clearly understood that student confidently will be maintained wherever possible.
☐	I authorize the staff of school of school and its agents to administer the designated treatment and to obtain suitable medical assistance. I agree to assume all costs associated with the medical treatment and absolve the staff of school and the Coquitlam School Board of the responsibility for any adverse reactions resulting from the administration of the designated medication.

This agreement must be reviewed at the beginning of every school year and when changes occur

Parent / Guardian Last Name Parent / Guardian First Name Date