Bal Bharati PUBLIC SCHOOL
Sector-21, Noida, G.B. Nagar

Circular No.117/2024-25 Date: 11 Dec, 2024

MEDICAL ALERT NOTIFICATION

Dear Parent,

Regular attendance at school is essential for effective learning. However, simply being present does not guarantee productive learning experiences. To maximize learning, a child needs to be in good health. Moreover, a sick child attending school risks spreading illness to others. It has been observed that some students report to school on exam days and request early dispersal. Please note that the school has a policy in place to conduct re-examinations for students who are medically unfit.

It is recommended that a child remains at home, if any of the following conditions are present.

i) Temperature of 100^0 or higher.
ii) Vomiting and/or Diarrhea with a loss of Appetite and/or Fever.
iii) Pain that requires narcotic medication for relief.
iv) Conjunctivitis – Redness of Eyes.
v) A rash that is itchy and spreading and the cause is unknown.
vi) If suffering from any communicable disease.

PARENTS ARE ADVISED TO ENSURE THAT THEIR CHILD JOINS THE SCHOOL ONLY AFTER COMPLETING THE INCUBATION PERIOD AND OBTAINING A MEDICAL FITNESS CERTIFICATE FROM A CERTIFIED MEDICAL PRACTITIONER.

It is only 'Sound Health' that promotes overall well being of a child. With a view to minimizing reaction time in providing emergency medical assistance to students who require such help, it is imperative that the school has data regarding such cases.

Parents of children with health related issues are requested to fill the attached Medical Alert Form regarding the state of health of their wards and submit it to the respective Class Teachers.

Please note, if your ward is a part of SCHOOL SPORTS TEAM, but is suffering from any contagious disease, the participation of the student will be permissible only if the School Doctor clears the student for participation. No student will be allowed to participate in SPORTS until medically cleared by the School Doctor.

In the event of a serious accident, an emergency service will be arranged at once and the parents will be contacted immediately. A member of the teaching staff, usually Home Room Teacher will accompany the casualty to the Hospital Emergency Department. In less serious cases, parents will be requested to collect their child from the school and arrange for further treatment.

It is important for parents to inform the school of any changes in their emergency contacts and also furnish particulars of the person who will be responsible for their child, if parents are out of NOIDA.

Please find attached the Medical Alert form to be filled in by each parent for the information of school.

Wishing all Bal Bharatians the very pink of health !

Encl. : As Above

Asha Prabhakar
(Principal)

स्वच्छ भारत
एक कदम स्वच्छता की ओर

WE STAND COMMITTED TO SDGs

Bal Bharati PUBLIC SCHOOL
Sector-21, Noida, G.B. Nagar

MEDICAL ALERT FORM

Please read the instructions given below carefully. Feel free to contact the school if you need any clarifications.

This document contains EIGHT pages as we have combined all FOUR medical forms into one to make it easier for parents to find them and fill them out. This will ensure that the school has all the necessary forms completed to maintain an safe and efficient procedure for all students.

Complete only the appropriate form(s) and submit them as soon as possible to comply with the School Management Policy.

Instructions :

- Read the description for each form and choose which applies to your child.
- Indicate which form(s) you need to complete by selecting the checkbox next to that form.

CHECKBOX Select all that applies	**FORM NAME** Click on form button to access from	**DESCRIPTION**	**PAGES**
☐	Medical Alert Form	Complete this form if your child has a medical condition that needs precautionary treatment or medication at school	2 to 3
☐	Request for Administration of medication	Complete this form ONLY if your child needs medication administered at school.	4
☐	Vaccination form (Mandatory for all PS & PP parents to fill)	Complete this form ONLY if your child needs an anaphylaxis emergency action plan*	5 to 6
☐	General Health form	Complete this form ONLY if your child needs a diabetic action plan* at school	7 to 8

(The information collected on this form is subject to and protected by the provisions 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 student 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 medical 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

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[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	AGE 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 MEDICAL PRACTITIONER

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