Eunoia Forest School
Individualized Plan and Emergency Procedures
for a Child with Medical Needs

***** denotes mandatory information

Child's Photo

Child's **name**:

_____

Date of birth:

_____

Date plan completed:

_____

Emergency Services: Call **911**

Medical **condition**(s):

☐ Diabetes ☐ Asthma ☐ Seizure ☐ Anaphylaxis ☐ Other Allergy ☐ Other:

_____

_____

***Signs and symptoms** of each medical condition (specific to the child):

* Procedures to follow if child has an allergic reaction or other **medical emergency**:
* Procedures to follow during an **evacuation** (e.g., ice packs for medication that requires refrigeration, how to assist the child to evacuate):
* Procedures to follow during **other emergencies**:

***Steps and Strategies for managing** the Medical Condition(s)
(describe **supports available at Eunoia**, **routine daily management strategies** and **who will and is authorized to perform** the strategies, **steps to reduce the risk of causing or worsening** the medical condition(s), and what **accommodations** will be made, if necessary, to support the strategies and to support the child's participation in all Eunoia activities):

_____

_____

_____

_____

_____

_____

_____

* List of **medical devices** and how to use them:

_____

_____

_____

_____

_____

Medication Information				
Name of Medication (include brand)	**Expiry Date**	***Location**	***Location of Extras**	**Disposal Instructions**

Additional information related to the medical condition (e.g., notes and instructions from a health professional):

☐ Eunoia's Emergency Management and Fire Safety/Evacuation Policy and Procedures was considered as this plan was created.

☐ The child's preferences were considered as this plan was created.

☐ This plan has been created in consultation with the child's parent/guardian.

*The parent/guardian has trained at least the Owner/Operator on procedures to follow if the child has an anaphylactic reaction: ☐ Yes; Date of training: _____

☐ Not applicable (child is not at risk for anaphylaxis)

Parental Statement

I, _____ (parent/guardian), hereby give consent for my child, _____, to:

☐ carry their emergency medication in the following location (e.g., blue fanny pack around their waist):_____

and/or

☐ self-administer their own medication as needed

AND/OR

I, _____ (parent/guardian), hereby give consent for any person with training on this plan to administer my child's emergency medication and to follow the procedures set out in my child's Individualized Plan

AND/OR

I, _____ (parent/guardian), hereby give consent for my child's signs and symptoms to be shared with their peers for the purpose of helping identify when a medical incident occurs

AND/OR

I, _____ (parent/guardian), hereby give consent for this plan to be shared with:

☐ all staff at Eunoia ☐ all volunteers at Eunoia

☐ the following members of the Eunoia team:

_____

and/or

☐ third party contractors who have direct contact with my child, if deemed necessary by Eunoia staff.

AND/OR

I, _____ (parent/guardian), acknowledge that I am responsible for notifying Ellisha Blair or a staff member as soon as possible if there are changes to my child's medical needs.

Parent/guardian initials: _____

Communicating about the Plan (specify **format** and **frequency** for communication between a parent/guardian, the Owner/Operator or Designate, the child, health professionals, and/or Eunoia staff. Identify **any other individuals** who should be involved in communication):

_____

_____

_____

***Emergency Contact Information – Provide contact information for at least 2 people**

Contact Name	Relationship to Child	Primary Phone #	Additional Phone #

The following **individuals participated** in the development of this plan (optional):

First and Last Name	Role	Signature

Signature of **health professional** (optional)

X	Date:

* Signature of **parent/guardian**

Print name:	Relationship to Child:
X	Date:

☐ Having seen that the parent/guardian consents for the child's signs and symptoms to be shared with their peers for the purpose of helping identify when a medical incident occurs, I, Ellisha Blair, hereby authorize such disclosure.

***** Signature of **owner/operator**

X	Date: