Life Threatening Conditions Information Management
~ Bussing ~

Authorization for the collection of this information is in the Education Act. Users of this information may be principals, teacher, support staff, volunteers, bus operators and drivers. This form will be kept for a minimum period of two school years and then shredded. The collector of this information is the General Manager of the Consortium or designate.

STUDENT INFORMATION
(to be completed by parents and school)

BUS COMPANY: _____ BUS ROUTE # : _____

NAME OF STUDENT: _____

SCHOOL: _____ GRADE: _____

Home Location:

Mailing Address:

Home Telephone: _____ Medic Alert I.D _____

Name of Father: _____ Cell Phone No. _____

Name of Mother: _____ Cell Phone No. _____

Emergency Contact: _____ Cell Phone No. _____

Name of Physician: _____ Clinic No. _____

Health Card # : _____

STUDENT PHOTO

Please email photo to bussing@nwobus.ca

PARENT/GUARDIAN COMMITMENTS

- ❑ **Complete 'Life Threatening Condition Information Management' Form**
- ❑ **Provide a Recent Photo**
- ❑ **Complete 'Emergency Action Plan'**

Parent Agreement

I, _____, acknowledge my participation in assisting School Board/Consortium staff in the collection of information on life threatening conditions for students utilizing the transportation and agree to execute reliably the parent commitments listed. I give my consent for the staff or bus driver servicing _____ School to execute the plan. I understand that this plan will be reviewed annually and I will update the Consortium if circumstances change before review.

I/We acknowledge that it is neither the objective nor purpose of the school staff or bus driver to administer medication to students and understand that the school is prepared to undertake this activity as a last resort. In the event of an emergency, I authorize the appropriate school staff or the bus driver to administer the designated medication and obtain suitable medical assistance (epi-pen only). I agree to assume responsibility for all costs associated with medical treatment and absolve the Keewatin-Patricia DSB; Kenora Catholic DSB; Northwest Catholic DSB; CSDC Aurores boreales; and their employees, of responsibility for any adverse reactions resulting from the administration of the medication.

I give my permission for this medical information to be accessible by the school and on the school bus and shared with the appropriate personnel.

Parent/Guardian Signature: _____ Date: _____

NEXT PAGE - IMPORTANT

NORTHWESTERN ONTARIO
Student Services Consortium

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EMERGENCY ACTION PLAN FOR

_____

Name of Student

MEDICAL INFORMATION

Medical Concerns:

Symptoms:

Medication and Dosage:

Additional Instructions or Information:

STEPS TO TAKE IN THE EVENT OF AN EMERGENCY

1.

2.

3.

4.