

SCHOOL DISTRICT #43 (COQUITLAM)

MEDICAL ALERT FORM

*** Parents must complete Section I and II and sign on reverse.
If necessary the school will complete Section III. ***

I. Student Name: _____ Date of Birth: _____

Care Card # _____

Parent/Legal Guardian: _____

Contact Telephone #'s: (Home): _____

(Mother's or Guardian's Work): _____

(Father's or Guardian's Work): _____

Other: (Name and Phone Number): _____

Name of Physician: _____ Telephone Number: _____

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

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

THIS FORM MUST BE REVIEWED AT THE START OF EACH SCHOOL YEAR

II. 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? (Circle One) YES NO

If yes, what medication?: _____

Parents or legal guardian must complete a REQUEST FOR ADMINISTRATION OF MEDICATION FORM which is also available from your school principal. Parents/Guardians need to assure that this medication does not go past its expiry date. It is the obligation of the parents/guardians to keep a current supply of any required medication at the school.

Signature of Parent/Legal Guardian

Date

III. If training is required to administer the medication, please identify who has given the training and when it was completed. Please be aware that parents/guardians are most often the trainer. However, if assistance from the Public Health Nurse is required, please contact your school nurse:

* Training on: _____

* Name of Trainer: _____ Date of Training: _____

* People Trained:

Print Name

Signature

Date

Print Name

Signature

Date

Print Name

Signature

Date