



MEDICAL ALERT FORM

Medical Alert Form	SCHOOL YEAR:
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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:		Father/Guardian Last Name:	
Mother/Guardian First Name:		Father/Guardian First Name:	
Home Phone#		Mother/Guardian's Work or Cell	Father/Guardian's Work or Cell
Physician Name		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):

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?

Yes

No

If yes, what medication?

Prescribing Physician:

Parents must complete a **Request for Administration of Medication Form** if their child needs medication administered at school.

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.
By typing your name in the boxes below, you are digitally signing this form.**

Parent/Guardian Last Name

Parent/Guardian First Name

Date

Copies to: ___ Parent(s) ___ Student G4 File ___ Medical Alert Red Binder ___ With medication
 ___ Nursing Support Care Plan (if necessary) ___ TOC Sub book ___ Child's Fanny Pack