

Medical Alert Information Sheet

School:	Date:
Name of Student:	Date of Birth:
Parent/Guardian:	(Parent) Signature:
Home Tel #:	Bus. Tel #:
Physician:	Tel:
PHN / Care Card:	

To Be Completed by Parent:

Emergency Action Plan			
Student Information	Medical Condition	Symptoms	Plan of Action (Number in order of priority: 1=Most important – 5 Least important)
Child's Name: Grade: Class/home room Teacher:	<input type="checkbox"/> Diabetes <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Clotting Disorder <input type="checkbox"/> Heart Condition		<input type="checkbox"/> Administer Medication <input type="checkbox"/> Call 911 <input type="checkbox"/> Call Parents <input type="checkbox"/> Provide juice/snack (if appropriate for diabetes. etc.) <input type="checkbox"/> Other

To be completed by prescribing Physician if emergency medication is required at school (e.g. rescue inhalers, seizure medication, and food for diabetic students):
(Please Print)

Medication	Dose	Route	Frequency	Directions
Physician's Name:		Signature:		