Chilliwack School District

Form 506.1 (A)

fraserhealth
Better health. Best in health care.

MEDICAL ALERT FORM

Student Picture If available

Name _____ Birthdate *(Year, Month, Day)* _____

Parent or Guardian _____ Home Ph. _____ Work Ph. _____

Physician _____ Phone _____

Diagnosis: _____

If your child has these conditions please check:

Epilepsy	Severe Allergies	Diabetes
Anaphylactic Shock	Severe Asthma	EpiPen Required
Blood Disorders	Other _____	ADHD

Parent's Comments:

_____

_____

If an attack does occur at school, please check off those actions that apply. Also please indicate the order in which they should be done.

Check	Order			
		Call 9-1-1		
		Call parents / guardians	Home _____	Work _____
			Cell _____	Pager _____
		Call this emergency contact	Name _____	
			Phone # _____	
		Administer Medication		

To request medication be administered at school (regularly or on an emergency basis) please complete the next page.

Parent Signature: _____

Administrator Signature: _____

Date Record Initiated: _____

Response Plan Required: Yes No

Date Reviewed	Signature Public Health