APF 503-1 MEDICAL ALERT INFORMATION FORM

CARIBOO - CHILCOTIN SCHOOL DISTRICT

Students Name:		Date of Birth: (m/d/y)
Parent or Caregiver:	Home/Cell 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 _____	

Parent's Comments:

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

Check	Order		
☐	☐	Call 9-1-1	
☐	☐	Call parents / caregiver	Home: _____ Cell: _____ Work: _____
☐	☐	Call Emergency contact	Name: _____ Phone: _____
☐	☐	Administer Medication	Name: _____

To request medication be administered at school (regularly or on an emergency basis) please complete a Request for Medication at School form.

Parent / caregiver Signature:

Administrator Signature: _____

Date Record Initiated: _____

Response Plan Required: ☐ Yes ☐ No