



SCHOOL DISTRICT NO. 51 (BOUNDARY)

MEDICAL ALERT SYSTEM

Student Name _____ Date of Birth _____

Care Card Number _____

Parent/Guardian Name and phone numbers

1. _____ mobile: _____ home: _____

2. _____ mobile: _____ home: _____

Name of Physician _____ Phone Number _____

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

Describe the potential problem (including symptoms that may be observed).

THIS FORM MUST BE COMPLETED AT THE START OF EACH SCHOOL YEAR
Please check the signature/date at the end of this form to ensure it is current
Destroy all outdated forms

Describe the necessary action or intervention to appropriately treat this medical condition:

Step 1: _____

Step 2: _____

Step 3: _____

Step 4: _____

Is medication needed? YES NO

If yes, what medication? _____

Where is it located? _____ Expiry Date _____

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

Signature of Parent/Guardian

Date