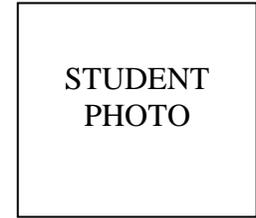




SCHOOL DISTRICT NO. 51 (BOUNDARY)

MEDICAL ALERT SYSTEM



Student Name _____ Date of Birth _____

Care Card No. _____

Parents' Names

Telephone: Home _____ Mum's Work _____ Dad's Work _____

Other: Name & Phone Number _____

Name of Physician _____ Phone Number _____

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

Describe the potential problem (include 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Destroy all outdated forms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	
Step 5	

Is medication needed? (circle one) YES NO

If yes, what medication? _____

Where located? _____ Expiry Date _____

Parents must complete a **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

Date

NOTE: All school staff have received Anaphylaxis training.

THIS FORM MUST BE COMPLETED AT THE START OF EACH SCHOOL