MEDICAL ALERT INFORMATION FORM – ELEMENTARY/MIDDLE

Student's Name: _____ ***Date of Birth:*** _____

SPECIFIC INFORMATION ON THE POTENTIALLY LIFE THREATENING CONDITION:

1. New Condition ☐ Yes ☐ No Date condition identified: _____
2. Describe the condition and *symptoms* to watch for:

_____

_____

_____

_____

MEDICATION needed: ☐ yes ☐ no **TYPE OF MEDICATION:** _____

DIRECTIONS FOR ADMINISTRATION: _____

_____

_____

_____

I agree to supply the medication to the school in the **original container** with child's name and the pharmacists direction for use including dosage. *The parent/guardian is responsible for replacing expired medication.*

PRECAUTIONS IN THE CLASSROOM ARE: _____

_____

INSTRUCTIONS: SCHOOL STAFF need to, should a problem/emergency occur: (step by step information needed)

1. _____
2. _____
3. _____
4. _____

Information to be collected at school registration and forwarded by the principal to the appropriate School Staff who consult with the Public Health Nurse as necessary.

I understand it is the parent's responsibility to update this information and/or medication annually and when the child's condition changes.

A request for disclosure

There are circumstances when our school would like to have "after hours" or emergency contact with parents. We need your specific consent to release information to the following individuals:

☐ Yes, I give my consent to provide the class phoning parent with my telephone number for the purpose of contacting me regarding special notices or events in my child's classroom.

☐ Yes, I give my consent to provide the Parent Advisory Executive with my telephone number for the purpose of contacting me regarding notice of meeting, special events or my opinion on school issues.

☐ Yes, I *am aware that the* school, as part of its emergency response plan, may maintain my record of emergency contacts at an off-site location.

☐ Yes, I *am aware that* the Public Health Nurse is to be informed of my child's potentially life threatening condition and medication, and that the Public Health Nurse may contact me as necessary.

I understand that I will be able to have my name and telephone number removed at any time during the school year by contacting the school office.

_____ _____

Date Signature of Parent/Guardian