MEDICAL ALERT INFORMATION FORM – SECONDARY

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:

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MEDICATION needed: ❒ yes ❒ no **TYPE OF MEDICATION:** ____________________________

DIRECTIONS FOR ADMINISTRATION: ____

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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: ____

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

1. ____
2. ____
3. ____
4. ____
5. ____

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.

I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication, and that the Public Health Nurse may contact me as necessary.

______________________________ ______________________________

Date Signature of Parent/Guardian