FOR LIFE THREATENING CONDITIONS ONLY

Please Check Medical Condition

General . Asthma Diabetes Epilepsy

MEDICAL ALERT INFORMATION AND CARE PLAN (General)

Student Name: ____

Birthdate: ______________________ Personal Health Number: ______________

Date Information Provided: ______________________________________

Date when this information was reviewed by Parent/Guardian (minimum annually):

____________ (date of review)	____________ (date of review)	____________ (date of review)
____________ (date of review)	____________ (date of review)	____________ (date of review)

School Emergency Contact Information:

	Name	Phone Number
Family Doctor		
Mother		
Father		
Alternate Contact		
Alternate Contact		
Alternate Contact		

Medical Condition (Physician diagnosed): ______________________________________

____

Specific Symptoms to watch for:

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

Surrey Schools

Procedures to deal with a problem: – GENERAL –

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Additional Comments: ____________________

____

Medication needed: ☐ YES ☐ No Location at the School: ____________________

Medication is Self-Administered: ☐ Yes ☐ No

Name of Medication: ____________________ Expiry Date: ____________

Details (Specific side effects, storage, etc.): ____________________

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Training Documentation:

Name of School	Date of Training/Review	Trainer

- I am aware of Board Policy and Regulation of the Treatment of Students with Medical Problems.
- I agree that the above information is correct.
- If changes occur I will contact the school and provide revised instructions.
- I agree that if medication is required I will supply it to the school in the original container with my child's name and the pharmacist's direction for use, including dosage.
- I am aware that no medication will be administered until this form is completed and returned.
- I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication and that the nurse may contact me as necessary.
- I am aware that staff working with my child my need to know of my child's condition and of the medication required.
- I am aware I am required to update this information each September.

____________________ (date)

____________________ (Signature of Parent/Guardian)