Chilliwack School District

Form 506.1 (A)

MEDICAL ALERT FORM

Student Picture If available

Name | Birthdate *(Year, Month, Day)*

Parent or Guardian | Home Ph. | Work Ph.

Physician | Phone

Diagnosis: ____

If your child has these conditions please check:

- ☐ Epilepsy
- ☐ Anaphylactic Shock
- ☐ Blood Disorders
- ☐ Severe Allergies
- ☐ Severe Asthma
- ☐ Other _______________
- ☐ Diabetes
- ☐ EpiPen Required
- ☐ ADHD

Parent's Comments:

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If an attack does occur at school, please check off those actions that apply. Also please indicate the order in which they should be done.

Check	Order			
☐	☐	Call 9-1-1		
☐	☐	Call parents / guardians	Home _________________	Work _________________
			Cell _________________	Pager _________________
☐	☐	Call this emergency contact	Name _________________	
			Phone # _________________	
☐	☐	Administer Medication		

To request medication be administered at school (regularly or on an emergency basis) please complete the next page.

Parent Signature: ___________________________

Administrator Signature: ___________________________

Date Record Initiated: ___________________________

Response Plan Required: ☐ Yes ☐ No

Date Reviewed	Signature Public Health