Chilliwack School District

Form 506.1 (A)

fraserhealth
Better health. Best in health care.

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:

_____

_____

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