Chilliwack School District

Form 426A

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 ____________________ Cell ____________________	Work ____________________
☐	☐	Call this emergency contact	Name ____________________ Phone # ____________________	
☐	☐	Administer Medication		

To request medication be administered at school (regularly or on an emergency basis) please complete Form 425A / Form 425C.

Parent Signature: ______________________________

Administrator Signature: ______________________________

Date Record Initiated: ______________________________

Response Plan Required: ☐ Yes ☐ No

Date Reviewed	Signature Public Health