

MEDICAL ALERT FORM

Section 1 - to be completed for each student .

Student Name: _____ Grade: _____

Birthdate: _____ / _____ / _____
Year Month Day

B.C. Care Card Number: _____

Note: If alternate medical plan, give name of plan and number: _____

Parent or Guardian: _____

Parent's Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Phone: _____

Physician: _____ Phone: _____

Please check the appropriate box:

- ◇ **My child has no medical concerns. (No physician signature necessary.)**
- ◇ **My child has medical concerns – complete section 2. (Physician signature required.)**

Parent signature _____ Date _____

Section 2 – to be completed by families whose child(ren) have allergies or critical/life-threatening conditions.

PLAN WHILE IN THE CARE OF THE SCHOOL

Potential life threatening medical condition diagnosed as: _____

New Condition: Yes No Date condition identified: _____

Brief description of the potential problem: _____

Symptoms: _____

Precautions in the classroom: _____

