# APF 503-1 MEDICAL ALERT INFORMATION FORM

CARIBOO - CHILCOTIN SCHOOL DISTRICT

| | | |
|---|---|---|
| Students Name: | | Date of Birth: (m/d/y) |
| Parent or Caregiver: | Home/Cell Ph. | Work Ph. |
| Physician: | Phone: | |

Diagnosis:

If your child has these conditions, please check:

| | | |
|---|---|---|
| ☐ Epilepsy | ☐ Severe Allergies | ☐ Diabetes |
| ☐ Anaphylactic Shock | ☐ Severe Asthma | ☐ EpiPen Required |
| ☐ Blood Disorders | ☐ Other _____ | |

Parent's Comments:

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

| Check | Order | | |
|---|---|---|---|
| | | Call 9-1-1 | |
| | | Call parents / caregiver | Home: _____<br>Cell: _____<br>Work: _____ |
| | | Call Emergency contact | Name: _____<br>Phone: _____ |
| | | Administer Medication | Name: _____ |

To request medication be administered at school (regularly or on an emergency basis) please complete a Request for Medication at School form.

Parent / caregiver Signature:

Administrator Signature: _____

Date Record Initiated: _____

Response Plan Required: Yes No