

FORM 503-1 MEDICAL ALERT INFORMATION FORM



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:		
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Severe Allergies	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Anaphylactic Shock	<input type="checkbox"/> Severe Asthma	<input type="checkbox"/> EpiPen Required
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Other _____	
Parents' 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: _____ Cell: _____ Work: _____
	Call Emergency contact	Name: _____ 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