

**MEDICAL ALERT INFORMATION FORM – SECONDARY**

*Student's Name:* \_\_\_\_\_ *Date of Birth:* \_\_\_\_\_

**SPECIFIC INFORMATION ON THE POTENTIALLY LIFE THREATENING CONDITION:**

1. New Condition       Yes       No      Date condition identified: \_\_\_\_\_

2. Describe the condition and *symptoms* to watch for:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICATION needed:**     yes     no    **TYPE OF MEDICATION:** \_\_\_\_\_

**DIRECTIONS FOR ADMINISTRATION:** \_\_\_\_\_

\_\_\_\_\_

I agree to supply the medication to the school in the **original container** with child's name and the pharmacist's direction for use including dosage. *The parent/guardian is responsible for replacing expired medication.*

**PRECAUTIONS IN THE CLASSROOM ARE:** \_\_\_\_\_

\_\_\_\_\_

**INSTRUCTIONS: SCHOOL STAFF** need to, should a problem/emergency occur: (step by step information needed)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Information to be collected at school registration and forwarded by the principal to the appropriate School Staff who consult with the Public Health Nurse as necessary.

I understand it is the parent's responsibility to update this information and/or medication annually and when the child's condition changes.

I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication, and that the Public Health Nurse may contact me as necessary.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Parent/Guardian