New Westminster Schools

School District No. 40

Medical Alert Form

Student Photo to be supplied by the school.

Student's Full Name: _____ Birthdate: _____

☐ Wears Medic Alert ID

First Parent/Legal Guardian Same address as child ☐ Yes ☐ No

Full Name: _____ Relationship: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ Email: _____

Second Parent/Legal Guardian Same address as child ☐ Yes ☐ No

Full Name: _____ Relationship: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ Email: _____

Physician/Licensed Medical Practitioner Name: _____ Phone: _____

Alternate Guardians/Emergency Contacts

	Full Name	Address/City	Phone	Alternate Phone
1.				
2.				

If you child has these conditions, please check:

☐ Epilepsy/Seizure Disorder ☐ Diabetes ☐ ADHD

☐ Blood Disorder ☐ Severe Asthma ☐ Other: _____

☐ Anaphylactic Shock (Form 317-1) Epinephrine Auto-Injector Required

☐ Severe Allergies - List Allergens: _____

For Epilepsy/Seizure Disorder: (please fill in):

Main triggers:	
Warning symptoms:	
Describe what happens during a seizure:	
Describe the care to provide before & after a seizure:	
How often does a seizure occur?	*When was the last seizure?*
When would you like to be contacted following a seizure?	
At what point to call ambulance? Standard procedure is following a 5 min or longer seizure	

Is an Emergency Response Plan Required?: ☐ **Yes** ☐ **No**

Please complete Form 315-2 Request for Administration of Medication at School (regularly or on an emergency basis) if necessary

	Signature	Date Reviewed
Parent / Guardian:		
Principal / Designate:		
Date Record Initiated:		

MEDICAL ALERT: SUPPLEMENTAL CARE PLAN

Requested ☐Y ☐N

To be completed for other serious health / potentially life threatening conditions not captured on page 1

For School Year _____

Physician/Licensed Medical Practitioner Name: _____ Phone: _____

Signature: _____

Potentially life threatening medical condition diagnosis: _____

1. New Condition: ☐ Yes ☐ No Date condition identified: _____

2. Briefly describe the potential problem: _____

_____

_____

_____

PLAN WHILE IN THE CARE OF THE SCHOOL:

To be updated annually and when the child's condition changes. The plan is updated by the student/parent, in consultation with the family physician and reviewed with principal in consultation with the public health nurse as needed.

Key symptoms to watch for are:

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

***EMERGENCY PLAN** school staff need to follow (step-by-step):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

INFORMATION REVIEW by parent/guardian:

(Review minimum annually)

1. _____ _____
   Signature Date
2. _____ _____
   Signature Date
3. _____ _____
   Signature Date
4. _____ _____
   Signature Date

TRAINING REVIEW by parent/guardian:

(Review minimum annually)

1. _____ _____
   Signature Date
2. _____ _____
   Signature Date
3. _____ _____
   Signature Date
4. _____ _____
   Signature Date