DCSS - Central Campus
Student Medical Alert Information

THIS FORM IS TO PROVIDE THE SCHOOL WITH ACCURATE AND UPDATED MEDICAL ALERT INFORMATION AND THE PLAN FOR STUDENTS WHILE THEY ARE IN THE CARE OF THE SCHOOL.

INFORMATION PROVIDED IN THIS FORM WILL BE SHARED ONLY WITH THE APPROPRIATE SCHOOL STAFF.

Student Name: ______________________ Birthdate (yyyy/mm/dd): ______________________

Parent/Guardian: ______________________ Date Information Provided (yyyy/mm/dd): ______________

Diagnosis/Condition: ______________________

Date Condition Identified (approx.): ______________________

Describe the condition (expected problem): ____

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School Emergency Contact Information

Who should we contact in the event of an symptoms being displayed? (check all that apply)

☐ Ambulance/911 ☐ Parent/Guardian ☐ Family Doctor

Parent/Guardian Name:	Phone #1:	Phone #2:
______________________	______________	______________
Alternate Contact Name:	Phone:	Relationship:
______________________	______________	______________
Family Doctor:	Phone:	
______________________	______________	

Symptoms to watch for: ____

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Medication

If there student is taking a medication for the condition or should be given medication (i.e. Epipen, Benadryl) at school, please complete the information below.

☐ Takes Medication for this condition Name of Medication: ______________________

Possible Side Effects: ______________________

☐ **School can Administer Medication** (only complete this bottom section if school is to give student medication)

Name of Medication: ______________________ Amount to be given: ______________

When should it be administered (time): ______________ Name of Physician Prescribing: ______________

Possible Side Effects: ____

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I, ______________________, the legal guardian of the above named student, confirm that my request for administration of medication at school for my child is necessary, in that the medication must be given during school hours. I HEREBY RELEASE School District #59 (Peace River South), its officers, directors, administrators, and employees, of any liability for any and all claims whatsoever that I might have or that I might bring on behalf of my child, in connection with my current "Request for Administration of Medication at School." I also hereby give permission for this information to be used by the School Based Team (Principal, classroom teacher, Learning Assistance teacher and other appropriate school personnel).

I understand that this authorization is valid for 12 months from the date of signature.

______________________ ______________________

Parent/Guardian Signature Effective Date