



Medical Alert Information Sheet						
School:			Date:			
Name of Student:			Date of Birth:			
Parent/Guardian:	(Parent) Signature:					
Home Tel #:		Bus. Tel #:				
Physician:	Tel:					
PHN / Care Card:						
To Be Completed by Parent:						
Emergency Action Plan						
Student Information	Medical Co	Medical Condition		toms	Plan of Action (Number in order of priority: 1=Most important – 5 Least important)	
Child's Name: Grade: Class/home room Teacher:	Seizure Asthma Blood C Disorder	☐ Diabetes ☐ Seizure Disorder ☐ Asthma ☐ Blood Clotting Disorder ☐ Heart Condition			Administer Medication Call 911 Call Parents Provide juice/snack (if appropriate for diabetes. etc.) Other	
To be completed by prescribing Physician if emergency medication is required at school (e.g. rescue inhalers, seizure medication, and food for diabetic students): (Please Print)						
Medication	Dose	Route		Fre	equency	Directions
]				
Physician's Name:			Signature:			