Vancouver CoastalHealth
Promoting wellness. Ensuring care.

North Vancouver School District
the natural place to learn®

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 Condition**	**Symptoms**	**Plan of Action** **(Number in order of priority: 1=Most important – 5 Least important)**
Child's Name: Grade: Class/home room Teacher:	☐ **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	Frequency	Directions

Physician's Name:	**Signature:**