New Westminster Schools

MEDICAL ALERT FORM

École Herbert Spencer Elementary School

Student's Full Name: _____ Birth Date: _____ YYYY - MM - DD

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

Full Name: _____ Relationship: _____ Home Phone: _____
Work Address: _____ City: _____ Work Phone: _____
Email: _____ Postal Code: _____ Cell Phone: _____

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

Full Name: _____ Relationship: _____ Home Phone: _____
Work Address: _____ City: _____ Work Phone: _____
Email: _____ Postal Code: _____ Cell Phone: _____

Physician/Licensed Medical Practitioner: _____ 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 ☐ EpiPen Required
☐ Anaphylactic Shock ☐ Severe Asthma ☐ Other: _____
☐ Blood Disorder ☐ ADHD ☐ Other: _____
☐ Severe Allergies List Allergens: _____

Parent/Guardian comments (Any additional information including symptoms that might be observed:

_____

Is an Emergency Response Plan Required? ☐ Yes ☐ No

If an emergency response is needed at the school, please check off those actions that apply. Also indicate the order (i.e. 1-5) in which they should be done.

Check all that apply	Order		Comments
☐	_____	Call 911	_____
☐	_____	Call Parent / Guardian	_____
☐	_____	Call Emergency Contact	_____
☐	_____	Administer Medication/ Intervention	_____
☐	_____	Other	_____

To request medication to be administered at school (regularly or on an emergency basis) please complete page 4.

	Signature	Date Reviewed
Parent/Guardian:	_____	_____
Principal/Designate:	_____	_____
Date Recorded Initiated:	_____	_____

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MEDICAL ALERT FORM

École Herbert Spencer Elementary School

Request for Administration of Medication at School **Check if not applicable** ☐

Student's Full Name: _____ School Name: _____

Section A – To be completed by prescribing physician / licensed medical professional.

Condition(s) which make medication necessary: _____

Name of Medication	Dosage	Direction for Use
1.		
2.		
3.		
4.		

Additional Comments (possible reactions, consequences of missing medication, storage duration):	Physician's Name:	
	Physician's Signature:	
	Date:	
	Office Stamp:	

Section B – To be completed by parent/guardian – Informed Authorization and Release
I request that staff give medication, as prescribed on this consent form to my child. I understand that:

- ✓ I agree to supply the medication to the school, in the original container with the child's name, prescribing physician and pharmacist's direction for use including dosage.
- ✓ If changes occur, I will contact the school and provide revised instructions. I am aware I am required to update this information each September.
- ✓ I am aware that the Nursing Support Services for the school will be informed of my child's condition and medication and the nurse may contact me directly as necessary.
- ✓ I am aware that staff and other personnel working with my child will need to know of my child's condition and the medication required.
- ✓ If non prescription medication is given, a note from the parent must be provided.

	Print Name	Signature	Date
Parent/Guardian Name:			