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:		

Student Photo
To be supplied
by the school.

School District No. 40

Request for Administration of Medication at 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	Times	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:			
Principal/Designate:			