hope lutheran
CHRISTIAN SCHOOL

MEDICAL ALERT FORM

Life Threatening:
☐ YES
☐ NO

Note: This form must be re-submitted at the start of each school year.

Student Name: _____ **Date of Birth:** _____

Parent/Legal Guardian: _____

Contact Telephone #'s: (Home): _____
(Mother's or Guardian's work): _____ **(Father's or Guardian's work):** _____

Name of Physician: _____ **Physician's telephone #:** _____

- **Indicate what medical condition this student has that may require emergency care at school:**

_____

_____

- **Describe the potential problem (include symptoms that might be observed):**

_____

_____

- **Describe the necessary action or intervention to appropriately treat this medical condition:**

STEP 1: _____

_____

STEP 2: _____

_____

STEP 3: _____

_____

STEP 4: _____

_____

- **Is medication needed? Yes ❑ No ❑ If yes, list medication below**

1	**3**	**5**
2	**4**	**6**

*Parents or legal guardian must complete a **Request for Administration of Medication Form** which is also available from your school principal. Parents/Guardian need to assure that this medication does not go past its expiry date. It is the obligation of the parents/guardians to keep a current supply of any required medication at the school.*

_____ _____
Signature of Parent/Legal Guardian Date

If training is required to administer the medication, please identify who has given the training and when it was completed. Please be aware that parent/guardian is most often the trainer. However, if assistance from the Public Health Nurse is required, please speak to the principal.

Training on: _____ Name of Trainer: _____

Date of Training: _____

People Trained:

Print Name	Signature	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____