



Medical Alert Card

Operation #1141.1

Student Name	Personal Health No.	Birthdate (Y/M/D)	
Parent/Guardian	Home Phone	Business Phone	
Emergency Contact	Home Phone	Business Phone	
Family Physician (In Pencil)	Phone (In Pencil)		
Diagnosis/Condition			
Date Condition Identified: (Y/M/D)		Date Reviewed (Y/M/D)	Parent Signature
Plan while in care of school (Review/Update Yearly) Symptoms to watch for: Restrictions at school: Emergency Procedures (See standard insert for insect stings, Epilepsy, Diabetes, Asthma) 1. 2. 3. 4. Is medication required: Yes _____ No _____ (If yes, Medication authorization form must be completed)			Physician or P.H.N. Signature
Parent/Guardian Signature _____			
Procedure reviewed and approved by P.H.N. or Physician _____			
Physician or PHN Signature _____			