Delta School District
"Where Learning Matters"

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)

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)

_____
Parent/Guardian Signature
Procedure reviewed and approved by P.H.N. or Physician

_____
Physician or PHN Signature

Date Reviewed (Y/M/D)	Parent Signature	Physician or P.H.N. Signature