Waterloo Catholic
District School Board

CRITICAL MEDICAL ALERT

School Year:

To be completed for HIGH RISK medical conditions ONLY

Name of Student: _____ Grade: _____

Homeroom Teacher: _____

Dangerous, Life-Threatening Conditions:

Please check all that apply. Note: if Anaphylactic, Asthmatic or Diabetic conditions exist for your child, additional form(s) for follow-up information will be sent to you.

☐ Anaphylactic Allergies ☐ Asthmatic ☐ Diabetic ☐ Epileptic
☐ Hemophiliac ☐ Heart Condition ☐ Seizures
☐ Other (please specify) _____

Please list Triggers, Symptoms:

Recommended Immediate Emergency Response: _____

Medication(s) Prescribed: _____

Note: If medication is to be taken at school, please contact the school for an Administration of Medication form.

Parent/Guardian Signature: _____ Date: _____

Disclaimer

Personal information on this form is collected under the authority of s. 265(1)(d) of the Education Act, and pursuant to sections 28(2) of the Municipal Freedom of Information and Protection of Privacy Act. The information collected on this form will be used for providing emergency medical treatment. Any questions regarding the collection of this information should be directed to the principal of the school. This form is kept in the School's Medical Emergency file, the OSR and provided to transportation service as required.

To be Completed by: Parent/Guardian
Description of Use: Copy filed in School's Medical Emergency File