NEOGA CUSD # 3
Medical Alert/ Medical Information Form
(Must be updated yearly)

Student's Name:_______ Birthdate:_____ Grade:_____

This Student has the following medical condition(s): (Check all that apply)

- Takes medication daily
  Name of Medication(s):_____
  Takes during school hours: _☐____Yes or _☐____No
  If yes, then you must have a Doctor fill out the Medication Authorization Form.

- Allergies: (please circle) medications foods insects seasonal other

  Please list specific medication, food, etc: _____

- Asthma – If your child will self-carry their inhaler, please fill out the Medication Authorization Form and attach a copy of the prescription label to the Medication Authorization Form.
- Reactive Airway Disease
- Diabetes
- Migraines
- Seizures
- Heart Problems
- Other: _____

Symptoms of medical condition: _____
_____

What should be done when symptoms occur? _____
_____

Is student currently under a physician's care for a medical issue? ☐___Yes or ☐____No

Physician's Name _________ Phone Number:_____

I understand that for my child's safety, this information may be shared with teachers, coaches, transportation personnel, and other school staff involved in my child's care at school. By signing this form, I also am granting the school nurse permission to contact the above named physician for medical/medicine information regarding my child's condition.

Parent/Guardian Signature: _____ Date:_____

Reviewed by District Nurse: _____ Date:_____