Students Name:		Date of Birth: (m/d/y)
Parent or Guardian	Home/Cell Ph.	Work Ph.
Physician	Phone	

Diagnosis:

If your child has these conditions, please check:

- ☐ Epilepsy
- ☐ Severe Allergies
- ☐ Diabetes
- ☐ Anaphylactic Shock
- ☐ Severe Asthma
- ☐ EpiPen Required
- ☐ Blood Disorders
- ☐ Other _______________

Parent's Comments:

If an attack does occur at school, please check off actions that apply. Also, please indicate the order in which they should be done.

Check	Order		
☐	☐	Call 9-1-1	
☐	☐	Call parents / guardians	Home: ____________ Cell: ____________ Work: ____________
☐	☐	Call Emergency contact	Name: ________________________________ Phone: ____________
☐	☐	Administer Medication	Name: ________________________________

To request medication be administered at school (regularly or on an emergency basis) please complete a Request for Medication at School form.

Parent Signature: ________________________________

Administrator Signature: __________________________

Date Record Initiated: __________________________________

Response Plan Required: ☐ Yes ☐ No