



EMERGENCY MEDICAL
ALERT FORM

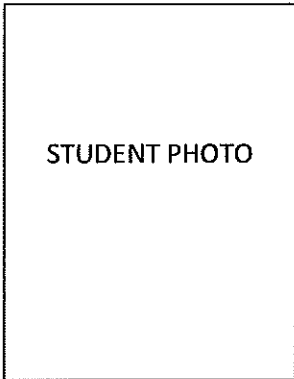
Student Name: _____

Class: _____ Date of birth: _____

CONDITION: _____

Condition Severity (*please shade*)

LOW				HIGH
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Medicare number: _____

Symptoms and signs of Condition (please print clearly)

- _____
- _____
- _____

Treatment/Medication (please print clearly)

- _____
- _____
- _____

EMERGENCY CONTACTS

Phone numbers:	Mobile	Home / Work
Mother		
Father		
Medical facility		

Parent Signature _____ Date: _____