Student Name: _____

MEDICAL INFORMATION

Condition	Allergies (specified below) Anaphylaxis Asthma Diabetes Mellitus Type 1 Epilepsy Febrile Convulsions Other (specified below)	
Date Recorded		
Static Alert	on / off	(activates alert indicator on student banner)
Alert Description		
Seriousness	Management Plan	No Management Plan
Treatment of Symptoms		
Doctor (optional)		
Other Medical Information (optional)		
Active	on / off	(indicates if record is current)

MEDICATION INFORMATION

Medication	Prescription	Non-prescription
Details of medication		
Static Alert	on / off	(activates alert indicator on student banner)
Alert Description		
Associated condition		
Date recorded		
Contact Doctor	on / off	
Authorisation Received		
Authorisation provided by		
Doctor's letter received	on / off	
Active	on / off	(indicates if record is current)

Student Name: _____

MEDICAL INFORMATION

Condition	Allergies Anaphylaxis Asthma Diabetes Type 1 Epilepsy Febrile Convulsions Other (specified below)	
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Alert Description		
Associated condition		
Date recorded		
Contact Doctor	on / off	
Authorisation Received		
Authorisation provided by		
Doctor's letter received	on / off	
Active	on / off	(indicates if record is current)