

Medical Alert Form



Primary/Secondary Department

School year 2026-2027

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| www.isecampus.nl

Student Name:		DoB:
Gender:	Class Group:	Teacher/Year Tutor:
Parents contact Email: Phone number:		
Medical Diagnosis/Concern:		
Symptoms (please describe the symptoms that the student might experience)		
Treatment (Please include any treatment instructions. If medication is needed please list name of medication, dosage, frequency, and instructions below):		
Is 112 (ambulance) to be called during an event? Yes No		
If yes, at what stage in treatment:		
Additional Information: Please include any information pertinent to the safety of your child.		
Medication: • Name(s): • Dosage(s): • Frequency: • Route: • Time: Is this medication in school: Yes No Please note ALL medication must be kept by either the School Nurse or Class Teacher unless otherwise agreed. Signature: Date: *Please also fill out a Permission for School Administration of Prescription Medications form if the medication may need to be taken at school* Note: parents need to ensure medication does not expire. It is the obligation of parents to keep a sufficient supply of any required medication at the school.		

To be filled out by school:

Read and checked by:

Date: