(For administration of medication or other special assistance to students with medical conditions.)

School: _____

Student Name: _____ AHC (optional) _____

Medical Condition: _____

If medical condition is an allergy, include substance(s) student is allergic to: _____

If the medical condition/allergy is potentially fatal or debilitating, please complete the following:

1. Symptoms exhibited at onset:

   _____
   _____
   _____
   _____

2. If medical condition is an allergy, please advise:
   a. Allergy Specialist: _____ Phone: _____
   b. Eating Rules (if any) : _____
   c.

Mild Attack Symptoms	Moderate Attack Symptoms	Severe attack Symptoms

3. Medical procedure to be followed when student is under distress due to named medical condition/allergy:
   a. _____
   b. _____
   c. _____
   d. _____
4. Parent/Guardian Emergency Contact Number: _____
5. Name of medication (if any) to be administered in emergency situations:

   _____
   a. Dosage: _____
   b. Method of Administration: _____
   c. Possible Side-Effects: _____
   d. Special Storage Instructions: _____
   e. Termination date (if any) of administering medication:_____
   f. Student ability to self-administer medication: _____
   g. Timeframe in which medication must be received:_____

The student's physician affirms that administration of medication to the student as requested by the parent is within the competence of an adult untrained in medical procedures.

Physician's Signature: _____ Date: _____

☐ **I confirm that I have the authority to sign this consent and will inform any other parent or guardian of the contents of this consent and the fact it has been signed.**

☐ **I confirm I have advised the Transportation Department about this student's severe medical condition/allergy.**

Parent/Guardian Signature: _____ Date: _____