Student Medical Information Form

2015-2016

The purpose of this form is to ensure that the school is aware of any medical conditions the student has that might be affected by, or, that might prevent him/her from engaging in any student activity including P.E. classes, athletic events, field trips, class studies and/or overnight trips. It is assumed by the school that, where necessary, the parents have sought the advice of the student's physician prior to completing this form.

GRADE _____ TEACHER _____ STUDENT'S LAST NAME _____ STUDENT'S FIRST & MIDDLE NAMES _____ USUAL FIRST NAME _____

☐ MALE ☐ FEMALE CARE CARD NUMBER _____ DATE OF BIRTH _____
MONTH / DAY/YEAR

PARENT'S MAIN EMAIL ADDRESS _____ CHURCH ATTENDING _____

SECONDARY STUDENT'S EMAIL ADDRESS _____

BIRTHPLACE _____ PRIMARY LANGUAGE SPOKEN _____
CITY / PROVINCE / COUNTRY

	FATHER	MOTHER
Parent Name (Last, First):		
Custodian's Name (Homestay) (For International Students)		
Marital Status:	Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Single ☐ Remarried ☐	
Student lives with:	Both Parents ☐ Mother ☐ Father ☐ Guardian ☐ Custodian ☐ Other ☐	
Home address including postal code:		
Home Phone Number:		
Business Phone Number:		
Cellular Number:		

ALTERNATE PERSON TO CONTACT IF PARENT(S) / LEGAL GUARDIAN(S) CANNOT BE REACHED:

NAME: _____ HOME PHONE # _____ CELL PHONE # _____

DOCTOR'S NAME: _____ DOCTOR'S TEL. # _____

NOTE: The responsibility lies with the parent/guardian/custodian to advise the school if any change occurs in the medical or physical condition of the student at any time during the school year.

Does the student have any medical problems, health concerns, and / or diet restrictions, and / or allergies of which the teacher or school nurse should be aware?

☐ **No** ☐ **Yes**

My child has the following Medical Condition(s) (check all that apply):

☐ **Allergies or Asthma** (e.g. specific drugs, certain foods, insect stings, hay fever) Specify: _____

_____
(PLEASE include reaction(s) staff should be aware of)

Is this allergy life threatening? Is any immediate emergency medical care, such as adrenalin, to be given by school staff? ☐ No ☐ Yes
Child carries Epi pen ☐ No ☐ Yes Inhaler ☐ No ☐ Yes Medical Alert Bracelet ☐ No ☐ Yes

☐ My child has a **medical or physical condition**(s) that may affect his/her participation in the course program or typical school activities (e.g. recent illness or injury, recent hospitalization or surgery, chronic condition(s), phobias, etc.) Specify: _____

_____

☐ My child **requires PRESCRIBED medications** during school hours to be self-administered ? ☐ No ☐ Yes
* Administered by staff? ☐ No ☐ Yes Completion of a "*Student Medication Form*" is required for all students who are taking prescribed medications. This additional form may be obtained from any campus office.

The information supplied on this form will be regarded as confidential and shall be made available to the student's current teachers, administration staff and appropriate persons as deemed necessary by School Administration.

IN CASE OF EMERGENCY: I hereby give permission to qualified health personnel (the family physician, the school nurse, other outside emergency medical personnel or staff who possess a current first aid certificate) to provide treatment for my child. I accept that any costs associated with the administration of medical treatment shall be borne by the parent or guardian.

SIGNATURE OF PARENT OR GUARDIAN _____ **DATE** _____
(mm/dd/yy)