Medical Information Form (1)

Student: _____ Date of Birth: _____

Parent/Guardian: _____ Telephone: (H) _____ (C) _____

Grade/Class_____ Ontario Health Number: _____

Family Doctor: _____ Telephone: _____

Medical Conditions

Please indicate any significant medical conditions, physical limitations, or any other concerns that might affect your child's full participation in school activities.

- ☐ Asthma
- ☐ Fainting Spells
- ☐ History of head injuries
- ☐ Chronic Nosebleed
- ☐ Feet or Leg problems
- ☐ Chronic Migraine
- ☐ Seizures
- ☐ Diabetes
- ☐ Hemophilia/Bleeding disorders
- ☐ Digestive upsets
- ☐ Heart problems
- ☐ Recent illness or operation
- ☐ Chronic Urinary infections
- ☐ Chronic Ear, Nose, Throat infections
- ☐ Other _____

Details of treatment for each of the above conditions indicated: _____

Previous communicable diseases: Date: _____ Illness: _____

Previous illness or injuries requiring hospitalization: Date: _____ Injury/Illness: _____

Special medical conditions or known allergies: _____

Medical Information Form (2)

Please explain if your child/ward has any medical condition that requires any modification of his/her program.

Is your child up to date on their immunizations ☐ Yes ☐ No

Allergies/Asthma

Please list all known confirmed allergies to the following:

(a) Foods: If foods are life-threatening, please explain the symptoms and the treatment:

_____

_____

(b) Medications: _____

(c) Other (e.g., bee or wasp stings, environmental allergies): _____

Has your child suffered any serious allergic or asthmatic reaction? Y / N

If so, please provide details, including the type and severity of reaction:

Is allergy considered: Mild____ Moderate____ Serious____ Life-Threatening____

Has a doctor prescribed an Epi-Pen for your child? Yes____ No____

Has a doctor prescribed an inhaler for asthma? Yes____ No___

Has a doctor prescribed an inhaler for any other reason? Yes____ No____

Dietary Restrictions

Please list any foods your child/ward should not eat for medical or dietary reasons: _____

_____

_____

Medical Information Form (3)

Medication

Does your child/ward take prescribed medication on a regular basis? Please specify:

What prescribed medication(s) should your child/ward have with him/her during school trips?

General

(1) Does your child wear or carry medical alert identification (e.g., bracelet)? Yes____ No____

If yes, please specify what is written on it:

(2) Does your child wear/use any special devices such as hearing aids, limb braces, glasses, etc? Yes____ No____

If yes, please explain: _____

(3) Does your child have any special fears or conditions (e.g., anxiety, bed-wetting, nightmares, etc)? Yes____ No____

If yes, please explain: _____

_____

_____

Should it become necessary for my child to have medical care, I hereby give the teacher/staff member permission to use her/his best judgment in obtaining the best of such service for my child. I also understand that in the event of such illness or accident, I will be notified as soon as possible.

Name of Parent/Guardian: _____ *(Please print)*

Signature of Parent/Guardian: _____Date: _____

Name of Parent/Guardian: _____ *(Please print)*

Signature of Parent/Guardian: _____Date: _____