



Medical Information Form

The collection and retention of the information requested on this form is authorized and governed by the Ontario *Education Act* and the *Municipal Freedom of Information and Protection of Privacy Act*.

511E
August 2010
Mono Cliffs OEC

The following information will be helpful to the teacher in making your child/ward comfortable and safe.

Student: (First Name) _____ (Last Name) _____ Date of Birth: _____

Teacher: _____ Grade/Class: _____ Boy: _____ Girl: _____

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

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/ward's full participation in excursions/school activities.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> History of head injuries | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Chronic Nosebleed | <input type="checkbox"/> Feet or Leg problems | <input type="checkbox"/> Migraine | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia/Bleeding disorders | <input type="checkbox"/> Rash | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Digestive upsets | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Recent illness or operation | <input type="checkbox"/> Urinary infections |
| <input type="checkbox"/> Ear, Nose, Throat infections | <input type="checkbox"/> Hernia | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Dislocated shoulder; swollen, painful joints; 'trick or lock' knee or other joint disability | | | |

Give details of usual treatment for each of the above conditions indicated: _____

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

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/ward suffered any serious allergic or asthmatic reaction?

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/ward? Yes _____ No _____ (Prescribed Epi-pens **must** be carried by the student on the excursion)

Has a doctor prescribed an inhaler for asthma? Yes _____ No _____ (Prescribed asthma inhalers **must** be carried by the student on the excursion)

Has a doctor prescribed an inhaler for any other reason? Yes _____ No _____ (Currently prescribed inhalers **must** be carried by the student on the excursion)

Dietary Restrictions (please check where appropriate)

Please indicate if there are any foods your child must or must not eat for medical, dietary or religious reasons: Please be specific.

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 the excursion?**

General

(1) Does your child/ward wear or carry medical alert identification (e.g., bracelet)? Yes _____ No _____

If yes, please specify what is written on it: _____

(2) Does your child/ward have any other relevant medical condition that will require modification of the program? Yes _____ No _____

If yes, please explain: _____

(3) Does your child/ward have any special fears or conditions (e.g., anxiety, bed-wetting, nightmares), the knowledge of which will allow the teacher to make the student's excursion more relaxed? Yes _____ No _____ If yes, please explain: _____

Should it become necessary for my child/ward to have medical care, I hereby give the teacher permission to use her/his best judgment in obtaining the best of such service for my child/ward. 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: _____