

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*.

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

Student: _____ Date of Birth: _____
 Teacher: _____ Grade/Class: _____
 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 _____ | |

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____

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____

Dietary Restrictions

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

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: _____