



# Student Medical Information

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## CONFIDENTIAL INFORMATION

### STUDENT INFORMATION (Please print)

Legal Family Name:	Legal First Name:	Legal Middle Name(s):	
Usual Family Name:	Usual First Name:	Usual Middle Name(s):	
Street Address:		City:	
Mailing address if different from above:		Postal Code:	
Home phone:	Birthdate:	Grade:	Gender:
<b>Parent/Guardian:</b>		Relationship:	
Place of Employment:		Work Ph:	Cell:
<b>Parent/Guardian:</b>		Relationship:	
Place of Employment:		Work Ph:	Cell:
<b>PERSONS TO CONTACT IN CASE OF EMERGENCY (OTHER THAN PARENTS/GUARDIANS):</b>			
1.	Relationship:	Phone:	
2.	Relationship:	Phone:	
<b>MEDICAL INFORMATION</b>			
<b>Personal Health Number:</b>			
Doctor:		Ph:	
Dentist:		Ph:	
<b>Does this child have any of the following? Please check all applicable conditions.</b>			
Asthma:	Diabetes:	Epilepsy:	
Hearing problem:	Heart condition:	Vision Problem: Contacts?	
Allergies: If yes, are the allergies mild _____ or severe _____ Please specify allergy(s):			
Other medical conditions:			
<b>Explain briefly about the above conditions or attach information:</b>			
Is your child able to participate in a full physical education program? Yes _____ No _____ If "No", an exemption note from your family physician will be required as physical education is a compulsory subject. If conditions change during the year please inform the school.			
<b>Signature of Parent/Guardian:</b>			<b>Date:</b>