

STUDENT MEDICAL INFORMATION



Comox Valley
CHRISTIAN SCHOOL

2085 Wallace Ave.
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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:
Parent/Guardian:		Relationship:	
Place of Employment:		Work Ph:	Cell:
Parent/Guardian:		Relationship:	
Place of Employment:		Work Ph:	Cell:
PERSONS TO CONTACT IN CASE OF EMERGENCY (OTHER THAN PARENTS/GUARDIANS):			
1.	Relationship:	Phone:	
2.	Relationship:	Phone:	
MEDICAL INFORMATION			
Personal Health Number:			
Doctor:		Ph:	
Dentist:		Ph:	
Does this child have any of the following? Please check all applicable conditions.			
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:			
Explain briefly about the above conditions or attach information:			
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.			
Signature of Parent/Guardian:			Date