

MEDICAL INFORMATION FORM
St. Andrew's Regional High School
SCHOOL YEAR: September 2010 to June 2011

Please complete both sides in full and return to the office as soon as possible.

Child's Name _____ **Grade** _____ **Tag** _____

Parents/Guardian:

Mother/Guardian _____ Day phone _____
Cell phone _____

Father/Guardian _____ Day phone _____
Cell phone _____

Emergency Contact (other than parent):

Name: _____ Day phone _____

Family Doctor _____ Day phone _____

BC Medical # (Care Card) _____ **Date of Birth:** _____

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- ◆ If your child has a serious medical problem that may be an emergency situation at school, contact the Public Health Nurse assigned to the school at 744-5100.
 - ◆ If your child requires medication to be kept at the school in case of an emergency situation (i.e: severe allergy to bee stings), you must have a "Request for Administration of Medication at School" card filled out by your family doctor and the parent/guardian before any medication can be kept in the office. This card is available at the school office. **A new card must be completed at the beginning of each school year.**
 - ◆ If your child's medical condition changes during the school year, please contact the school and the Public Health Nurse for the school. It is recommended that parents update the nurse *every September*.
 - ◆ This form **MUST** be completed by parent/guardian at the beginning of **EACH SCHOOL YEAR.**

Please complete reverse side *

Please complete the following medical information at the beginning of each school year.



Please indicate if your child has any of the following medical problems:

Student's Name _____ Grade _____ Tag _____

Allergies (list) _____

◆ requires emergency treatment? YES NO
(i.e. are allergies life threatening? Needs to go to hospital immediately?)

Asthma: mild severe

◆ requires emergency treatment? YES NO
specify medication: _____

Diabetes requires insulin? YES NO

Epilepsy

◆ type: _____

◆ needs medication? YES NO name of medication _____

Heart Condition

◆ nature of problem: _____

◆ physical activity limited? YES NO

◆ specify limitations: _____

Hearing

◆ nature of problem: _____

◆ wears hearing aid? YES NO

Vision

◆ nature of problem: _____

◆ wears contacts lenses? YES NO

Other

◆ specify: _____

◆ list any medications required for treatment/control of condition: _____

Medications to be kept in the office for one of the above medical conditions? YES NO