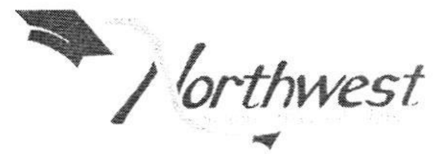


Health Information Form

Please complete the form attached and have your child return to his/her teacher

Name of Student: ______________________________

Heath Care Number: ______________________________

Doctor's Name: ______________________ Number: ___________________________

Parent/ Guardian contact: __________________________

Phone Numbers: Work: _______________ Home: _______________

Emergency Contact Person: ________________________

Number: ___________________________

Teacher's Name: _____________________

1. Please indicate if your child has experienced any of the following and provide pertinent details:

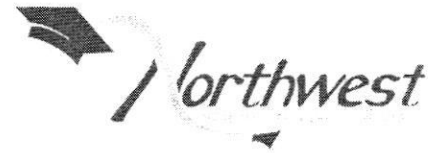
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Orthopedic Problems
- ☐ Hearing Disorders
- ☐ Asthma
- ☐ Chronic Nosebleeds
- ☐ Arthritis/ Rheumatism
- ☐ Head/ Back conditions or injuries
- ☐ Dizziness
- ☐ Headaches
- ☐ Fainting
- ☐ Dislocated Shoulder
- ☐ Hernia
- ☐ Hyper-Mobile or Painful Joints
- ☐ Trick or Lock Knee
- ☐ Any other condition we should be aware of (please specify below)

____

____

2. Please indicate if your child has any allergies, if so please list important details below

____



3. Medications:

a) **CONTACT THE SCHOOL REGARDING THE USE OF PRESCRIBED MEDICATION AT SCHOOL

b) **For non- prescribed medication

i) These may be used from school supplies: Yes: ☐ No ☐

ii) If yes please indicate which may be used: ______________________

iii) If yes indicate specific instructions: ______________________

**THE SCHOOL WILL CONFIRM THIS INFORMATION

4. Does your child wear a medic alert bracelet, neck chain or carry a medic alert card?

Yes ☐ No ☐ If yes, please specify what is written on it: ______________

____

5. Please describe any other relevant medical conditions that will limit your child's full participation in sports/ general activities: ______________________

____

Student's Signature: ______________________ Date: ____________

Parent's Signature: ______________________ Date: ____________

Principal's Signature: ______________________ Date: ____________