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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| STUDENT INFORMATION | | | |  | | | | | | | |  | | | | |  |
| Legal Name | | Last Name | | | | | First Name | | | | | | | Middle Name(s) | | | |
| Date of Birth | | MM-DD-YYYY | | | | | | | | | | | | | | | |
| Address | |  | | | | | City, Province | | | | | | | Postal Code | | | |
| Phone Number | | Res | | | | | | | Cell (optional) | | | | | | | | |
| Parent/ Guardian 1 | Last Name | | | | First Name | | | | | | | | Relationship to Student | | | | |
| Email | | | | | Res | | | | | Work | | | | Cell | | |
| Address (if different from student) | | | | | City, Province | | | | | Postal Code | | | |  | | |
| Parent/ Guardian 2 | Last Name | | | | First Name | | | | | | | | Relationship to Student | | | | |
| Email | | | | | Res | | | | | Work | | | | Cell | | |
| Address (if different from student) | | | | | City, Province | | | | | Postal Code | | | |  | | |
|  | | | | | | | | | | | | | | | | | |
| EMERGENCY AND MEDICAL INFORMATION | | | | | | | | | | | | | | | | | |
| Family Doctor | | | | | | | | Phone | | | | | | | | | |
| Dentist | | | | | | | | Phone | | | | | | | | | |
| In case of emergency, school closure, or if no one answers the home telephone number, please provide us with names and phone numbers of emergency contacts other than parents or guardians: | | | | | | | | | | | | | | | | | |
| Surname | | | First Name | | Relationship | | | | | Res | | | | | | Cell | |
| Surname | | | First Name | | Relationship | | | | | Res | | | | | | Cell | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Please check the appropriate response and provide details below if you answer “yes” to any of the questions: | | | | | | | |
| * Yes | * No | Medication | * Yes | * No | Asthma | | |
| * Yes | * No | Allergies | * Yes | * No | Trouble breathing during exercise | | |
| * Yes | * No | Carries an epiPen | * Yes | * No | Heart condition | | |
| * Yes | * No | Previous history of concussions | * Yes | * No | Diabetes | * Type 1 | * Type 2 |
| * Yes | * No | Wears dental appliance | * Yes | * No | Presently injured | | |
| * Yes | * No | Seizures and/or epilepsy | * Yes | * No | Head or back injury | | |
| * Yes | * No | Wears glasses | * Yes | * No | Surgery in the last year | | |
| * Yes | * No | Been admitted to hospital in the last year | * Yes | * No | Fainting or seizure during or after physical activity | | |
| * Yes | * No | Vaccinations up to date | * Yes | * No | Wears medical information bracelet /necklace | | |
|  |  | Date of last Tetanus Shot \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | For what purpose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| * Yes | * No | Has had injuries requiring medical attention in the past year | * Yes | * No | Other | | |
| Please give details if you answered “yes” to any of the above. (use a separate sheet if necessary) | | | | | | | |

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| --- | --- |
| DECLARATION | |
| I understand that it is my responsibility to keep the school advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, the school will arrange to take the student to the hospital or a physician if deemed necessary. I also authorize release of information to appropriate people (physician, nurse) as deemed necessary. | |
| Signature of Custodial Parent/ Legal Guardian/ Independent Student | Date (MM-DD-YYYY) |

**IMPORTANT:**

This information is collected under the Authority of the Freedom of Information and Protection of Privacy Act Section 33(c). This information will be used to identify practices or conditions which may affect the safety and care of individuals. For further information, you may call the Principal or the FOIP Coordinator at 780.674.8500.