



# STUDENT EMERGENCY HEALTH FORM



To ensure the safety of the student, the school must be informed of any health issues that may require emergency intervention while at school (e.g. severe allergy to certain foods/insect bites, diabetes, etc.).

**Does your child have a medical issue or condition?** YES NO

## STUDENT IDENTIFICATION

<b>Family Name :</b>		<b>Given Name :</b>	
Fiche no.	Class	Benchmark Group	Bus #
Language spoken at home :			
Date of birth :	Sex :	Male	Female
Other			
Siblings in the school :			

## MAIN ADDRESS

Civic no.	type (street, boul., ave...)	Street name	Appartement	City/borough	postal code
Home telephone number :			Other telephone number(s)		
The child resides with :		Both parents	One parent :	Guardian	

## EMERGENCY CONTACT INFORMATION

Name of parent	Name of parent
Home phone number	Home phone number
Work phone number	Work phone number
Cell phone number	Cell phone number
Email Address	Email Address

Name of guardian	Emergency contact
Home phone number	Home phone
Work phone number	Work phone number
Cell phone number	Cell phone number
Email Address	Email Address

Parents are advised to notify the above individuals that the school will contact them in an emergency.

**Please complete and sign the back**



## ADDITIONAL INFORMATION

### DOES THE STUDENT HAVE A SEVERE ALLERGY ?

Food	Yes	No	Specify :	
Bee/wasp stings	Yes	No	Specify :	
Other allergy			Specify :	
<b>Epinephrine auto-injector</b> (for example : EpiPen <sup>MD</sup> )	Yes	No	If yes, specify :	Expiration date :
Other :			Specify :	

### DOES THE STUDENT SUFFER FROM AN ILLNESS ?

<b>Asthma</b>	Yes	No	Specify :	Medication *(name and dosage of medication) :	Taken at school  Yes      No
<b>Diabetes</b>	Yes	No	Specify :	Medication *(name and dosage of medication) : Insulin dependant :                      Yes                      No	Taken at school  Yes      No
<b>Epilepsy</b>	Yes	No	Specify :	Medication *(name and dosage of medication) :	Taken at school  Yes      No
<b>Sickle Cell Anemia</b>	Yes	No	Specify :	Medication *(name and dosage of medication) :	Taken at school  Yes      No
<b>Heart problems</b>	Yes	No	Specify :	Medication *(name and dosage of medication) :	Taken at school  Yes      No
<b>Other</b>	Yes	No	Specify :	Medication *(name and dosage of medication) :	Taken at school  Yes      No
<b>Other</b>	Yes	No	Specify :	Medication *(name and dosage of medication) :	Taken at school  Yes      No

\*Please note that medication at school is an exceptional measure. You will need to authorize any medication administered at school and provide the prescription and medication in its original container. For any changes regarding your child's specific needs, please contact the school secretarial staff.

### AUTHORISATION

I give permission to display the name and photo of my child in order to allow quick intervention for the following health problems – asthma, epilepsy, sickle cell anemia, heart problems, allergies, other.	Yes	No
I authorise the nurse to screen for the presence of signs and symptoms of contagious and parasitic diseases (e.g. measles, chickenpox, ringworm, scabies, etc.) in order to make a medical referral and ensure follow-up.	Yes	No
<b>Ambulance transport</b> If transport by ambulance must be carried out, the costs will be paid by the parents or guardian.		

### SIGNATURE OF PARENTAL AUTHORITY HOLDER OR YOUTH 14 YEARS OLD AND OVER

signature	Date :
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