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? (Please circle one) ☐ **YES** ☐ **NO**

L.I.N.K.S. High School 2024 - 2025

STUDENT IDENTIFICATION

Family Name :				**Given Name :**
Fiche no.:	Class:	Benchmark Group:	Bus #:	Language spoken at home :
Date of birth: Year:_____ Month: _____ Day: _____				**Sex** (Please circle one): Male ☐ Female ☐ Other ☐
Sibling(s) in the school:				

MAIN ADDRESS

Civic no.:	**Type:** Str./Boul./Ave.	**Street name:**	**Appt #:**	**City/borough:**	**Postal Code:**

Home Tel. No: **Other Tel. No.**

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 Name:**	
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 ? (Please circle either a Yes or No)

Food: (Please circle one)	Yes No	**Specify :**	
Bee/wasp stings:	Yes No	**Specify :**	
Other allergy:		**Specify :**	
Epinephrine auto-injector (for example : EpiPen MD)	Yes No	**If yes, specify :**	**Expiration Date:**
Other :		**Specify :**	

DOES THE STUDENT SUFFER FROM AN ILLNESS ? (Please circle either a Yes or No)

Asthma: ☐ Yes ☐ No	**Specify :**	**Medication *(name & dosage of medication):**	**Taken at school** ☐ Yes ☐ No
Diabetes: ☐ Yes ☐ No	**Specify :**	**Medication *(name & dosage of medication):** Insulin dependant: ☐ Yes ☐ No	**Taken at school** ☐ Yes ☐ No
Epilepsy: ☐ Yes ☐ No	**Specify :**	**Medication *(name & dosage of medication):**	**Taken at school** ☐ Yes ☐ No
Sickle Cell Anemia ☐ Yes ☐ No	**Specify :**	**Medication *(name & dosage of medication):**	**Taken at school** ☐ Yes ☐ No
Heart problems: ☐ Yes ☐ No	**Specify :**	**Medication *(name & dosage of medication):**	**Taken at school** ☐ Yes ☐ No
Other: ☐ Yes ☐ No	**Specify :**	**Medication *(name & dosage of medication):**	**Taken at school** ☐ Yes ☐ No
Other: ☐ Yes ☐ No	**Specify :**	**Medication *(name & 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

Ambulance transport: 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

/	/		**Date:** / /
Please print Last Name	First Name	Signature	Year / Month / Day