**WILLINGDON SCHOOL**

# Emergency Health Record

## GENERAL INFORMATION—2021-2022

Last Name (student): _____School Grade: _____

First name: _____Homeroom No.: _____

Address: _____Language Spoken at home: _____

Gender _____ Date of birth: ____ / ____ / _____
Year Month Day

**Health Insurance No.** ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry Date: _____ / _____
Year Month

Where can you be reached in case of emergency:

| Primary Parent 1 | Primary Parent 2 |
|---|---|
| Name: _____ | Name: _____ |
| ☎ home: _____<br>☎ work : _____<br>☎ other : _____ | ☎ home: _____<br>☎ work : _____<br>☎ other : _____ |

| OTHER | OTHER |
|---|---|
| Name: _____ | Name: _____ |
| ☎ home: _____<br>☎ work : _____<br>☎ other : _____ | ☎ home: _____<br>☎ work : _____<br>☎ other : _____ |

In order to ensure the security of your child, the school must be informed of health problems that might require immediate intervention at school (severe allergy to food or insect bites, diabetes…).

Does your child suffer from such a health problem?

Yes ❒ If yes, complete the back of the sheet. No ❒

**Please inform the school of any change that might occur during the present school year.**

N.B.: The information contained in this sheet will only be transmitted to the school nurse and to the school staff who may be required to assist your child in case of emergency.

Parent Signature_____Date _____

over……

## Additional Information

**(Complete only if your child has health problems that may require immediate intervention at school.)**

**Has your child's state of health changed since last year:** Yes ❒ No ❒

**Does your child suffer from:**

**SEVERE ALLERGY:**

- ➤ **To food:** Yes ❒ No ❒
- ➤ **To insect bites** Yes ❒ No ❒
- ➤ **Other** Yes ❒ No ❒

**If so, specify** _____

_____

**Emergency medication:** Yes ❒ No ❒ **Epipen:** Yes ❒ No ❒

**Other:** _____

**DIABETES:** Yes ❒ No ❒

**Emergency medication:** Yes ❒ No ❒ **Specify:** _____

**Emergency care required, in case of hypoglycaemia, specify:** _____

_____

**OTHERS: Does your child suffer from any other problems that might require immediate assistance at school?** Yes ❒ No ❒

**If so, specify:** _____

**Medical recommendation in case of emergency:** Yes ❒ No ❒

**Specify:** _____

**I authorize the CLSC nurse to communicate the above information to the school staff that might be required to assist my child in case of emergency.**

_____ **Date:** ____ / ____/ ____

**Parent Signature** **Year Month Day**