

Medical Information Form

School, Physical Education, Off-Site Activities, Intramurals & Clubs

Student's Name:	
Home Address:	
Parent/Guardian Names:	
Home Phone #:	
Cell Phone #1:	
Physician Name:	
Physician Phone #:	
Health Card # (optional):	
Emergency Contact Name:	
Emergency Contact Phone #:	

NOTE: An annual medical examination is recommended.

MEDICAL INFORMATION

1. Date of last complete examination:

2. Date of last tetanus immunization:

3. Is your son/daughter/ward allergic to any drugs, food or medication/other? YES

NO

4. Does your son/daughter/ward wear a medical alert bracelet, neck chain, or carry a medical alert card? YES NO

- If yes, provide details.

5. Has your son/daughter/ward been identified as being anaphylactic? YES NO

If yes, does he/she carry an EpiPen? YES NO

6. Does your son/daughter/ward take any prescription drugs? YES NO

- If yes, provide details

- What medication(s) should the participant (son/daughter/ward) have available during the sport activity?
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- Who should administer the medication?
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7. Does your son/daughter/ward wear eyeglasses? YES NO

- Orthodontic appliances? YES / NO Crowns YES / NO Bridges? YES / NO

8. Please indicate if your son/daughter/ward has been subject to any of the following and provide pertinent details:

- Epilepsy, diabetes, orthopaedic problems, hearing loss, asthma, allergies, heart disorder
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- Head or back conditions or injuries
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- Diagnosed concussion (in the past three years)
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- Arthritis or rheumatism, chronic nosebleeds, dizziness, fainting, headaches, dislocated shoulder, hernia, swollen or hyper mobile or painful joints, trick or lock knee, etc.
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9. Please indicate any other medical condition that will limit participation or require modification to the activity program:

NOTE:

If a concussion has been diagnosed over the summer break, the Request to Resume Participation – Concussion Related Injuries form must be completed by a physician/physiotherapist/nurse practitioner before the student returns to class/intramural and interschool activities.