Medical Form

NAME OF STUDENT________________________________ DATE OF BIRTH ______________

NAME OF PARENT/GUARDIAN ____

IN CASE OF EMERGENCY CONTACT: PARENTS /OR ________________ PHONE ____________

A. Please note any health problem, physical handicap, emotional difficulty, behavioural problem, or facts which may limit full participation in the science classroom. ______________________

HOME PHONE ________________________ FAMILY DOCTOR ______________________

WORK PHONE ________________________ OFFICE PHONE ______________________

Medical Insurance Plan No.: ________________

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B. Student's immunization shots are current , i.e. tetanus and diptheria, typhoid, smallpox and polio vaccine

❑ YES ❑ NO

C. Student is subject to:

❑ asthma
❑ ear ache
❑ fainting
❑ tonsillitis
❑ eye infection
❑ sensitive skin
❑ sinus trouble
❑ frequent colds
❑ nightmares
❑ bronchitis
❑ sleepwalking
❑ convulsions
❑ headache
❑ bed wetting
❑ kidney problem
❑ nosebleed
❑ high blood pressure
❑ motion sickness
❑ allergies (describe)

D. Student wears contact lenses ❑

E. Medications: I would like my child to be given:

Name of Medication(s) ____

Purpose of Medication ____

* *

In case of emergency, I hereby give permission to the physician selected by the school to provide necessary treatment for my child.

Parent/Guardian signature: ______________________________ Date: ________________