Medical Information

TO BE COMPLETED BY PARENT/GUARDIAN

Name of Student: ___________________________ Birth Date: _____________
School: ____________________________________ Grade: ________________
Home Address: ____
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Telephone No. of Parent/Guardian (Home): ___________ (Work): _________

Name of Emergency Contacts: ______________________ Phone: _________
______________________ Phone: _________
Name of Physician: ________________________________ Phone: _________

Specific Potentially Life-Threatening Allergy(ies)

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The Nature of the Reaction (observed in past but not limited to)

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Tingling in mouth		Hoarseness	
Hives, rash, itching		Vomiting, stomach upset, diarrhea	
Generalized flushing		Sense of doom	
Swelling-eyes, ears, lips, face, tongue		Lightheadedness	
Constriction in throat, mouth and chest		Loss of consciousness	
Constriction in breathing, swallowing		Coma and death	
Wheezing, sneezing, coughing and choking			

Recommended Treatment in the Event of Accidental Exposure

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Date:____________________ Signature of Parent/Guardian: ____________________________________

Note: This form is to be filed in the School's Medical Emergency file and in the student's OSR File.

The information gathered on this form is pursuant to the *Education Act* and the *Municipal Freedom of Information and Protection of Privacy Act*. Information will be used to prepare assessment records; maintain records for all students. Users: Student Services Staff, Principal of Student, all teachers responsible for the Student's program and designated staff for clerical functions.