MEDICAL FORM – MOUNT SEYMOUR

Should your child need medical attention, the information on the form below will be necessary for the medical staff at the nearest area hospital. Please fully complete the attached form and return it to school by

Friday, Decmeber 8, 2017.

_____ _____ _____

Student's Surname | Given Name | Birth Date (month/day/year)

Care Card Number _____

In case of emergency, we should notify _____ _____

Full Name | Relationship to student

_____ _____ _____ _____

Address | Home Phone | Work Phone | Cell\Pager

Does your child suffer from any of the following conditions?

Hay Fever _____ Diabetes _____ Asthma _____ Convulsions _____ Bedwetting _____

Others (please specify)

_____

Is your child allergic to any of the following?

Drugs (aspirin, penicillin, others) _____ Insect Bites (bee, wasp, spider) _____

Plants (grasses, trees, etc.) _____ **Food** (nuts, milk products, wheat flour, etc.) _____

If your child has any allergies, what is the usual treatment?

_____

_____

Does your child have specific dietary needs?

_____

_____

Operations (if any)

_____

Date of last Tetanus shot _____

Current Medication

_____

(to be clearly labeled with student name and dosage required)

This is my permission for the official in charge to provide surgical or medical attention for my child/ward in the event of an emergency, without the necessity of my prior approval. It is understood that a responsible adult will ensure that my child receives proper medical attention and that arrangements are made for his/her return home, if deemed necessary. I understand that I will be notified by the quickest possible means if this authority is exercised.

_____ _____

Signature of Parent/Guardian | Date