Medical History

Mission Public Schools

The personal information on this form is collected by School District No. 75 (Mission) under the authority of the School Act. The information will be used for educational purposes. This information will be protected under the Freedom of Information and Protection of Privacy Act. Questions about the collection and use of this information should be directed to the Information and Privacy Coordinator, School District No. 75, 33046 4th Avenue, Mission, BC, V2V 1S5, 826-6286.

Section A - Student Information:

Name:_____

Home Address:_____

Date of Birth:_____ Age on January 1st:_____

Care Card Number:_____

Section B - Parent(s) / Legal Guardian Information:

Father's Name:_____

Home Address:_____

Home Phone:_____ Business Phone:_____

Employer:_____

Mother's Name:_____

Home Address:_____

Home Phone:_____ Business Phone:_____

Employer:_____

Section C – Alternate person to contact if above cannot be reached

Name:_____

Relationship to Student (if any):_____

Home Phone:_____ Business Phone:_____

Employer:_____

Section D – Physician Having Medical Records of Student (Family Doctor)

Name:_____ Office Address:_____

Office Phone:_____ After Hours Phone:_____

Name of Group Medical Coverage – Group Number – Identity Number:_____

Section E – Medical Alerts

Serious known allergies:_____

Precautions to be taken:_____

Known allergies to medicines or drugs:_____

Gravol may be administered in the event of motion sickness: Yes_____ No_____

Dietary Restrictions (state if medical or religious):_____

_____

Section F – General Health

Physical Illness (list any serious illness experienced in the last 12 months or any conditions for which you are now under a doctor's care):

_____

_____

Emotional Illness (indicate any emotional difficulties you have experienced for which you have received professional medical treatment):

_____

_____

Homesickness (has your child ever experienced the feelings of homesickness?): Yes_____ No_____ (If 'Yes', please give details, including the age when it was experienced)

_____

_____

Other (state details of any significant health problem not covered in the preceding, especially something that places limitations on activities to be engaged in, or that could require medical attention while travelling):

_____

_____

Section G – Medical Consent (to be signed by Parent or Guardian)

I certify that to the best of my knowledge the information supplied on this form provides a full and accurate account of the required medical information about the name student. I certify that the state of health of my son/daughter _____ (full name) is such that he/she can undertake the activities likely to be encountered on the Field Study within any restrictions stated in the information supplied on this form. I empower the teacher or adult chaperons to authorize any emergency medical treatment required by my son/daughter/ward until contact has been made with his/her parent or guardian.

Parent/Guardian Signature:_____ Date:_____

This form is to be completed and returned to the teacher before the student will be permitted to participate on the field trip/field study.