Lester B. Pearson High School 2020-21 School Year

STUDENT HEALTH FORM

Section A **Please Complete in *BLUE* Ink** ***Student Information***

Family Name_____First Name_____Middle Name_____

Address_____Appartment_____

City_____Postal Code_____Emergency Phone(____)_____

Day Phone Number(_____)_____ Home Phone(_____)_____

Student's Cell(____)_____ Language(s) spoken at home_____

Sex: _____Male _____Female Other: _____

Date of Birth: _____(year)/_____(month)/_____(day)

Health Card Number: ☐☐☐☐-☐☐☐☐-☐☐☐☐

Expiry Date: _____(Yr)/_____(Mo)

Section B ***Family Contact Information***

Student lives with: ☐ both parents ☐ shared custody ☐ mother only ☐ father only

☐ group home (please specify) _____

Person legally responsible for the student and who can be reached in case of an emergency is: _____

This person's relationship to the student is:

☐Mother ☐Father ☐Step-parent ☐Guardian ☐Other_____(please indicate)

Contact Information

Parent/Guardian	***Parent/Guardian***
Family Name:	Family Name:
First Name:	First Name:
☎(Home)	☎(Home)
☎(Work)	☎(Work)
☎(Cell)	☎(Cell)

Other Emergency Contact	***Other Emergency Contact***
Relationship to student:	Relationship to student:
Family Name:	Family Name:
First Name:	First Name:
☎(Home)	☎(Home)
☎(Work)	☎(Work)
☎(Cell)	☎(Cell)

****PLEASE INFORM THE SCHOOL* of any changes to the information above during the school year. *OVER PLEASE***

Section C **General Health Information**

In order to ensure the security of your child, the school must be informed of the health problems that require immediate intervention at the school (i.e. severe allergy, asthma, epilepsy, diabetes…).

Does your child suffer from any particular health problem that needs to be brought to our attention?

Yes ☐ (*please Complete Sections **D and E***) ***No*** ☐ (*Please complete Section **E - ONLY***)

Section D **Specific Health Conditions**

Does your child suffer from ***life-threatening*** allergies? ☐Yes ☐No

If yes, to what:_____

Emergency Medication: ☐Epipen ☐Twinject ☐Allerject

******It is the responsibility of the student to have their own medication either kept at school (primary) or on their person (secondary) at all times during the school day.***

Does your child suffer from ***Asthma***? ☐Yes ☐No

Emergency care required:_____

Does your child have ***Diabetes***? ☐Yes ☐No

Emergency care required:_____

Does your child have ***Epilepsy***? ☐Yes ☐No

Emergency care required:_____

Is there any further pertinent information about which the school should be informed in order to respond to an emergency for your child?

If Yes, please specify:_____

Section E **CONSENT**

I understand that the information contained in this form will only be transmitted to the CLSC Nurse and to the School Authority who may be required to assist my child in the case of an emergency. I authorise said assistance by the CLSC and/ or School/EMSB personnel.

Signature_____ Date_____

(Parent/Guardian or student from age 14) (Year – Month – Day)

I authorise the CLSC nurse to assess my child on an "as-needed" basis, understanding that this will require the opening of a medical file at the CLSC by the CLSC Nurse.

Signature_____ Date_____

(Parent/Guardian or student from age 14) (Year – Month – Day)

Important Reminder: Parents are encouraged to subscribe to personal accident insurance in case their child gets hurt while participating in physical education and sports or in any other circumstances. Fees incurred for ambulance services, medical/dental/ocular services and any other services related to an injury will not be assumed by the school. Parents are encouraged to contact their personal insurance company or any other insurer to get advice and information about accident insurance coverage for their child. Any other questions should be addressed to a member of the administration.