



## STUDENT MEDICAL ALERT FORM



This form must be completed if your child has a medical issue. Please return to the office manager.

STUDENT NAME: \_\_\_\_\_ SEX: M / F

DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

PARENT OR GUARDIAN NAME: \_\_\_\_\_

TELEPHONE NO: Home: (        )                      Work: (        )                      Other: (        )

PROVINCIAL HEALTH NO: \_\_\_\_\_

OTHER MEDICATION TAKING: \_\_\_\_\_

ALLERGIES: Yes / No If yes, describe: \_\_\_\_\_

RECENT HOSPITALIZATION FOR ASTHMA? Yes / No

MEDICATIONS FOR ASTHMA: \_\_\_\_\_

OTHER MEDICATIONS TAKING: \_\_\_\_\_

DOSAGES: \_\_\_\_\_

HEALTH PROBLEMS: Diabetes: Yes / No Epilepsy: Yes / No Heart: Yes / No Kidney: Yes / No

PLEASE EXPLAIN: \_\_\_\_\_

RECENT INJURIES: \_\_\_\_\_ DATE: \_\_\_\_\_

Fractures: Yes / No Dislocations: Yes / No Surgery: Yes / No

Hospitalizations: Yes / No Sprains/Strains: Yes / No

PLEASE EXPLAIN: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NO: (        ) \_\_\_\_\_

EYE GLASSES: Yes / No CONTACT LENSES: Yes / No HEARING PROBLEMS: Yes / No

SPECIAL DIET: \_\_\_\_\_

DATE OF LAST TETANUS SHOT: \_\_\_\_\_

OTHER COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE: \_\_\_\_\_ PARENTAL SIGNATURE: \_\_\_\_\_