_____School Medical Form
Please return this completed form by March 31, 2023

Student's Name:	Date of Birth
Home Address:	Home Phone #:
OHIP Number:	Name of Family Doctor:

Name	Daytime Phone #	Evening Phone #	Mobile Phone #
Mother:			
Father:			
Emergency Contact:			

Does your child have any of the following: (Please check)

Condition	No	Yes	If "Yes" on any of these, please give specific details:
Diabetes			
Epilepsy			
Asthma			
Other Concerns			

Does your child have any allergies we should be aware of: (Please check and add any details)

Type of Allergy	No Allergy	Yes, but non-life threatening	Yes, potentially life-threatening	If yes on any of these, please give specific details. This includes food sensitivities, dietary needs, etc.
Drugs				
Foods				
Other				

We will bring Tylenol, Advil, Gravol, Polysporin, etc. in our first aid kit. Students will not need to bring these with them if you give permission for us to administer these medications.

	I give permission _____	for the school staff to administer basic medications "as needed" to my child.
	I do not give permission	(Please check the appropriate box)

Does your child require any medication which he/she will bring? If "Yes", please list and add any details)

Condition	Drug / Medication	Frequency (or "as needed")	Dosage

	Please check here if you are attaching another page of instructions or information regarding your child's health.

Parent/Guardian Signature _____