North Vancouver School District
the natural place to learn

SCHOOL SERVICES
Ph: 604-903-3489
Fax: 604-903-3445

Student Medical Form

Name of Student: _____ Grade: ____

School: _____

Care Card Personal Health No.: _____ Birth Day (d/m/y): _____

Family Doctor: _____ Dr. Phone: _____

Name of Parent/Guardian: _____

Address: _____ Postal Code: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Please note any health condition or other factors that require support for participation in this program:

_____

Has the student had a previous injury that would require special first aid treatment should another injury occur?

_____

The student has received the regular immunization program administered in BC for: Diphtheria; Pertussis & Tetanus (DPT); Tetanus and Diphtheria (TD); Polio; Measles, Mumps and Rubella (MMR)

◯ Yes ◯ No If no, please explain: _____

Does the student wear Contact Lenses: ◯ Yes ◯ No

Student is subject to:

- ☐ Asthma
- ☐ Bronchitis
- ☐ Concussion
- ☐ Dislocations
- ☐ Dizziness
- ☐ Ear ache
- ☐ Enuresis (bed wetting)
- ☐ Eye infections
- ☐ Fainting
- ☐ Frequent Colds
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ Kidney problems
- ☐ Motion Sickness
- ☐ Muscle Pulls
- ☐ Nose bleeds
- ☐ Seizures
- ☐ Sensitive Skin
- ☐ Severe allergies/anaphylaxis (*provide details below)
- ☐ Sinus Problems
- ☐ Sleep walking
- ☐ Sprains
- ☐ Tonsillitis

Other conditions and/or *further detail (describe below)

_____

Alternate Emergency Contacts:

Name: _____ Phone: _____

Name: _____ Phone: _____

In case of emergency, I hereby give permission to the physician selected by the supervisor(s) to provide necessary treatment for my child.

Parent/Guardian Signature: _____ Date: _____

THIS INFORMATION WILL BE KEPT ON FILE