



# Personal Health Form - Students

1. Family Doctor: \_\_\_\_\_ Phone (     ) \_\_\_\_\_

2. Provincial Health Number \_\_\_\_\_

3. Are corrective lenses required? Yes \_\_\_\_\_ No \_\_\_\_\_ Contacts? Yes \_\_\_\_\_ No \_\_\_\_\_

4. If the student has allergic reactions to things such as food, insect stings, etc. please complete the following:

<i>Allergy</i>	<i>Life Threatening</i>	<i>Allergy</i>	<i>Life Threatening</i>
_____	Yes _____ No _____	_____	Yes _____ No _____
_____	Yes _____ No _____	_____	Yes _____ No _____
_____	Yes _____ No _____	_____	Yes _____ No _____

5. Is the student subject to any of the following?

_____ Arthritis	_____ Convulsions	_____ Motion Sickness	_____ Diabetes
_____ Ear Trouble	_____ Nightmares	_____ Respiratory	_____ Other (specify)
_____ Bed Wetting	_____ Sleepwalking	_____ Headaches	_____

6. Chronic conditions or recent illnesses that the staff should be aware of? \_\_\_\_\_

7. Please provide details of treatment required and name of medication the student will be bringing with them if required for the above medical condition.

8. Are there any dietary concerns or limitations of which the staff should be aware?

9. Are there any medications that the student should carry themselves? (inhaler, epi-pen etc.)

Yes     No     If yes, please specify: \_\_\_\_\_

**Medications:** Any medication (over the counter and / or prescribed) required by students must be brought in the original packaging with dosage instructions and clearly labelled with the students' name. Medications will be given to the designated adult upon arrival for the event. The designated adult will supervise the taking of the medication during the event. No medicine will be administered that has not been provided by the parent.

**Every care and attention will be given to the health and comfort of the participant.**

I hereby authorize a Menno Simons Christian School representative to secure medical advice and services (e.g. contacting EMS / ambulance) as may be deemed necessary for the health and safety of my child / ward during this event. I agree to accept financial responsibility in excess of benefits allowed by Alberta Health Care.

\_\_\_\_\_  
Signature of Parent / Guardian

Date: \_\_\_\_\_