

2018-2019

Emergency Health Form



Student's family name, first name: _____ Level: _____

Address: _____

No. Street City Postal code

Sex: F M

Date of birth: ____/____/____

Year Month Day

Medicare: _____

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Expiry date: ____/____

Year Month

The child lives with: mother/father mother father joint custody guardian

Father's name: _____ ☎ Home: _____ ☎ Other(off/cell./pager) _____

Mother's name: _____ ☎ Home: _____ ☎ Other(off/cell./pager) _____

Guardian's name: _____ ☎ Home: _____ ☎ Other(off/cell./pager) _____

☞ If there is an emergency and the parents or guardian cannot be reached, contact the following people:

1 st person to contact	2 nd person to contact
Family name/First name: _____	Family name/First name: _____
Relationship: _____	Relationship: _____
☎ (1) _____	☎ (1) _____
☎ (2) _____	☎ (2) _____

Please ENSURE YOUR CHILD KNOWS WHAT TO DO AND WHERE TO GO once off the bus in case of an EMERGENCY daytime school closure du to unforeseen circumstances.

▶ Does your child have a chronic health problem **that will not require an emergency intervention** at school?
 ☞ If yes, ⇨ specify: _____

▶ To ensure your child's safety, the school must be informed of any health problems that **may require emergency intervention at the school** (e.g.: severe allergy to certain foods or insect bites, diabetes, etc.)
 ☞ If your child has such a problem, **PLEASE ANSWER THE QUESTIONNAIRE ON THE BACK OF THIS PAGE** ☞

I authorize the information appearing on this form to be forwarded, if necessary, to the school staff and nurse, who may be required to intervene in case of an emergency involving my child.

Signature of parent or guardian

date

PLEASE NOTIFY THE SCHOOL OF ALL CHANGES DURING THE COURSE OF THIS SCHOOL YEAR.

Child's name: _____

**Informations
Emergency health**

DOES YOUR CHILD HAVE

	Yes	Specify
√ SEVERE ALLERGIES: ▶ Food	<input type="checkbox"/>	_____
▶ Insect bite (do not include localized reactions)	<input type="checkbox"/>	_____
Prescribed medication: Yes <input type="checkbox"/> Name? _____		

√ DIABETES: Yes <input type="checkbox"/> Specify: _____
Prescribed medication: Yes <input type="checkbox"/> Name? _____

√ OTHER: Does your child have another health problem that could require an emergency intervention at school ?
Yes <input type="checkbox"/> Specify: _____
Prescribed medication: Yes <input type="checkbox"/> Name?: _____

Comments:
