COMMISSION SCOLAIRE CENTRAL QUÉBEC
CENTRAL QUÉBEC SCHOOL BOARD

2046, Chemin St-Louis
Québec, QC G1T 1P4

STUDENT MEDICAL HISTORY

1. Student's Surname (Family name) :	2. Student's First Name (Given name) :

3. Previous surgery, injury and/or serious illness? *(Please specify)*
Date:

4. Fractures sustained? *(Please specify)*
Dates:

5. Allergies? *(Please specify)*			

6. Regular medication taken?	7. Do you use an inhaler?	8. Do you wear glasses / Contact lenses?
Over the counter ❑	Yes ❑ No ❑	Yes ❑ No ❑
Prescription ❑		

9. Do you require regular injections? *(If yes, please describe)*

10. Any family illness that we should be aware of? *(Please specify)*

11. Are you taking any medication at this time? *(If yes, please describe)*

12. Do you have an eating disorder? *(If yes, please explain)*

13. Are you under treatment for any medical or emotional conditions? *(If yes, please explain)*

14. Have you ever had any of the following? *(Please check all that apply)*

a.	Allergies to drugs ❑	n.	Measles ❑
b.	Food allergies ❑	o.	Menstrual cycle problems ❑
c.	Pet allergies ❑	p.	Mumps ❑
d.	Anorexia or bulimia ❑	q.	Poliomyelitis ❑
e.	Appendicitis ❑	r.	Pneumonia ❑
f.	Asthma ❑	s.	Rheumatic fever ❑
g.	Chicken pox ❑	t.	Scarlet fever ❑
h.	Cough (persistent, recurring) ❑	u.	Seizure disorder ❑
i.	Diabetes ❑	v.	Tonsillitis ❑
j.	German Measles ❑	w.	Tuberculosis ❑
k.	Migraines ❑	x.	Typhoid fever ❑
l.	Hepatitis ❑	y.	Vertigo, dizziness ❑
m.	Malaria ❑	z.	Ulcers ❑
			Others *(Please specify)*

15. Please list all vaccinations:

This medical information is being collected so that appropriate health care plans may be developed, if necessary.
This information will be kept strictly confidential and will only be shared with appropriate individual if necessary.

Emergency Health Profile

School Year 2025-2026

Student Identification

File Number | Group | School

Student's Last Name | Student's First Name

SEX | Date of Birth (YYYY-MM-DD)

Identification of Parental Authority

Parent Responsible: ☐ ☐ Guardian ☐

Last name of parent responsible	First name of parent responsible	Mobile of parent responsible	Email of parent responsible
Last name of parent responsible	First name of parent responsible	Mobile of parent responsible	Email of parent responsible
Last name of guardian	First name of guardian	Mobile of guardiar	Email of guardian

HOME ADDRESS IN QUEBEC

Civic Number | Type | Street | N, S, E, O | APP. | Postal box

City Municipality | Postal Code | Home Telephone Number

Work telephone of Parent responsible

HEALTH INFORMATION

In order for us to intervene as rapidly and as adequately as possible with your child, we ask that you inform us of all major health problems and of any particular situation that requires specific health care.

If there are any changes to your child's health during the school year, please contact the school Secretary

No Health Problems ☐

Does your child take medication? Yes ☐ If yes, please specify: _____

☐ Allergy ☐ Without Epipen Allergic to what? _____

☐ Epipen

☐ Asthma _____ Pump at school? ☐ Glasses: ☐

☐ Diabetes with insulin ☐ Diabetes without insulin Other _____

☐ Epilepsy

Handicap or important difficulty that requires particular attention: Yes ☐ Specify : _____

Emergency Situation

In case of an emergency **in the absence of parents,** who should we contact? **(please notify this person that they are your emergency contact)**

Name : _____ Check : Family ☐ Friend ☐ Neighbour ☐ Other ☐ Telephone : _____

If you have other children attending the same school, please indicate here :

Last name and First Name : _____ Last name and First name : _____

NOTE :Any transportation costs for an ambulance or taxi will be covered by the parents

AUTHORIZATION OF PARENTAL AUTHORITY

I authorize the school authorities to disclose, for security reasons, the information on this form to the CSSS personnel working at the school as well as to all the school personnel (principal, teachers, non-teaching personnel, daycare personnel and transport), and in case of emergency (accident or sudden illness) to take the necessary measures, to provide first aid and to ensure the transportation of my child to a treatment center, if it is necessary.

By reference from the school personnel or by request from my child, I authorise the CSSS nurse to carry out the necessary health interventions

X_____ **X**_____

SIGNATURE : Parent ☐ Parent ☐ GUARDIAN ☐ Date

Special Needs: _____