



Health Form



1. Student identification

_____	_____	_____
Student first name	Student last name	Group
_____	_____	_____
Address	City	Postal code
_____	_____	
Sex	Date of birth	

2. Parental identification

_____	_____	_____	_____
Father's name	Home phone number	Office phone number	Cell phone number
_____	_____	_____	_____
Mother's name	Home phone number	Office phone number	Cell phone number

Custody: Father and mother Father Mother Joint custody

Other _____

Emergency contact (if we are not able to reach the parents):

_____	_____	_____
First name and last name	Relation to child	Phone number

3. State of Health

Does your child suffer from any of the following?

✧ Asthma (medically diagnosed)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
✧ Diabetes	No <input type="checkbox"/>	Yes <input type="checkbox"/>
✧ Epilepsy	No <input type="checkbox"/>	Yes <input type="checkbox"/>
✧ Severe allergies (Allerject, Twinject or EpiPen)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
If yes, to what? _____		
✧ Other health problem(s) the school needs to be aware of?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Please specify _____		

1. Authorisation

By the following, I authorize the school and CLSC nurse to have access to the above information and to administer first aid in case of an emergency situation

_____	_____
Parent or Legal Guardian's Signature	Date