



STUDENT MEDICAL INFORMATION
CONFIDENTIAL INFORMATION

STUDENT INFORMATION

Family Name: _____ First Name: _____

Mailing Address: _____

Birthdate: _____ Age: _____ Male _____ Female _____

Parent/Guardian: _____ Phone: _____

MEDICAL HISTORY

Physical Condition _____

Does this child have any of the following? Please check

Asthma: _____ Diabetes: _____ Migraine Headaches: _____

Hearing problems: _____ Vision Problems: _____ Contact lenses: _____

Stomach problems: _____ Allergies: _____

Epilepsy: _____ Heart Conditions: _____

Other: _____

Briefly explain above condition (s)

Has your child had any surgeries? No _____ Yes _____

Tell us about the surgery _____

Explain briefly any medications the child is taking regularly and the prescribed dosage.

Has your child been receiving medical attention in the past year, before coming to Canada?

Yes _____ No _____

Please explain if the answer is “yes”.

Is your child able to participate in a full physical education program? Yes _____ No _____

If no, please explain why. _____

Does your child smoke? No _____ Yes _____

If your child wears glasses or contacts, please send a copy of the prescription (in English).

If your child takes medication, please send a copy of the prescription (In English).

Signature of Parent/Guardian:

Date: _____