

Registration and Medical Form

Name of Student: _____ Grade: _____ M/F: _____

School: _____

Care Card Personal Health No. _____ Birth Date (DDMMYY): _____

Family Doctor: _____ Phone: _____

Name of Parent/Guardian: _____ E-Mail: _____

Address: _____ Postal Code: _____

Phone (H) _____ (W) _____ (Cell) _____

Please note any health problems, physical handicap, emotional difficulty, behaviour problem, or other factors that may limit participation in this program.

Has the student had a previous injury that would require special first aid treatment should another injury occur?

The student has received the regular immunization program administered in BC for diphtheria, Pertussis & tetanus DPT: tetanus and diphtheria (TD); polio; measles, mumps and rubella (MMR)

Yes No (circle). If no, please explain _____

Contact Lenses: Yes No (circle)

Child is subject to:

() asthma () ear ache () fainting () tonsillitis () eye infection

() sensitive skin () seizures () sinus () nose bleeds () bronchitis

problems

() high blood () headaches () bed wetting () kidney

pressure problems

() dizziness () sprains () dislocations () motion

sickness

() frequent colds () muscle () sleep walking () severe allergies (describe below)

pulls

() other (describe)

Alternate Emergency Contacts:

Name: _____ Phone: _____

Name: _____ Phone: _____

I certify that to the best of my knowledge, the information supplied on this form provides a full and accurate account of the required medical information about the above named student. I certify that the state of health of the above named student is such that he/she can undertake the activities included in the "Informed Consent" document for this field trip within any restrictions supplied on this form. I will empower the chaperones to authorize any emergency treatment required to the above named student until such time as contact has been made with his/her parents or guardians.

Parent/Guardian Signature _____ Date: _____