BRITANNIA SECONDARY SCHOOL - STREETFRONT ALTERNATIVE PROGRAM

STUDENT MEDICAL FORM

Please note that the information contained herein is considered confidential and will only be shared with the staff and medical personnel in the event of a medical emergency. This information is important - **PLEASE PRINT CLEARLY**.

PARTICIPANT'S NAME: _____ BIRTHDATE (d/m/y):_____

HOME ADDRESS:_____ POSTAL CODE:_____

PARENT / GUADIAN NAME: _____

HOME TEL:_____ WORK TEL:_____ ALTERNATE TEL:_____

EMERGENCY CONTACT INFORMATION – *can include another parent*

NAME: _____ RELATIONSHIP: _____

ADDRESS:_____ POSTAL CODE:_____

HOME TEL:_____ WORK TEL:_____ ALTERNATE TEL:_____

DOCTOR'S NAME:_____ DR'S PHONE:_____

B.C. CARE CARD PERSONAL HEALTH NUMBER: _____

OTHER HEALTH/MED. INSURANCE:_____NUMBER:_____

Is your Child subject to any of the following?

Severe Asthma *Diabetes* *Seizure Disorder/Epilepsy*

ADD / ADHD *Other*

If yes, please give additional information: _____

_____

_____

ALLERGIES: ☐ *LIFE THREATENING/ANAPHYLAXIS* **or** ☐ *Non life threatening* **or** ☐ *No allergies*

☐ Foods _____ ☐ Animals _____

☐ Insects _____ ☐ Grasses/Pollens _____

☐ Drugs _____ ☐ Other _____

Describe what happens during a reaction:_____

_____

In the event of a reaction, what actions are necessary? _____

_____

Has your child ever been hospitalized due to a reaction: *Yes* *No* If yes, when? _____

What, if any, medication does your child carry for their allergy? _____

_____

CONTINUE ON SECOND SIDE

Has your child been under a **DOCTOR'S CARE** in the last 12 months? *Yes* *No* If yes, for what reason?

_____

Does your child suffer any **PHYSICAL LIMITATIONS**? *Yes* *No* If yes, describe:_____

_____

Does your child have any **PSYCHOLOGICAL LIMITATIONS** (E.g. fear of heights, fear of water, etc) *Yes* *No* If yes, describe: _____

Does your child experience any **BED TIME / SLEEPING DIFFICULTIES**? *Yes* *No* If yes, describe: _____

_____

Does your child have any **DIETARY RESTRICTIONS**? *Yes* *No* If yes, describe: _____

_____

Has your child ever had any **MAJOR ILLNESSES, INJURIES, or OPERATIONS**? *Yes* *No* If yes, describe:

_____

Is your child taking **ANY PRESCRIPTION OR NON-PRESCRIPTION DRUGS** *Yes* *No*

If yes, What drug?_____ How frequently? _____

When was your child's last **TETANUS** Inoculation or Booster (d/m/y)? _____

Tetanus must be current (within last 10 years) for ALL overnight wilderness trips

EYESIGHT: Excellent Good Fair Poor Glasses Contacts Laser Eye Surgery

HEARING: Excellent Good Fair Poor Require Electronic Hearing Aid

SWIMMING ABILITY: None Minimal Able to swim 25m Able to swim 100m Able to swim 1 km

How often does your child swim? Daily Weekly Monthly Several times per year Rarely

Do they have any swimming qualifications?_____

IMPORTANT NOTES

1. If your child wears **glasses** bring a second pair in case their first pair is broken or lost.
2. If your child wears **contacts** send a pair of glasses as back-up.
3. If your child is bringing **medication**: A. Check the expiry B. Send complete second set (that the instructor can carry) in case the first set is damaged or lost. C. Ensure all medication is labeled with child's name, drug name, dosage and expiry. D. Check with doctor/pharmacist regarding any contraindications or storage restrictions that might be affected by this trip.
4. We may treat our **drinking water** with iodine, chlorine or by boiling. Chemicals are not effective against Cryptosporidium. We recommend that immune compromised people bring an appropriate filter for their trip.

I confirm that the above information is correct and I hereby give consent and full authority for the staff of Streetfront Alternative Program to arrange for and consent to any medical treatment or hospitalization for my child/ward while he/she is in the care of the school. I further authorize these staff members to enter into and execute, on my behalf, such documents or consents as may be required by Medical Practitioners, Health Care Professionals or Hospitals for such purposes.

I understand that it is my responsibility to inform the staff of *Streetfront Alternative Program* of any new medical condition or change to this information as early as possible.

SIGNATURE OF PARENT/ GUARDIAN_____ DATE (d/m/y):_____

PRINT NAME:_____ RELATIONSHIP TO MINOR:_____