PROGRAMME MILE END

EMERGENCY HEALTH RECORD

Student name: _____

Medicare: __:__:__:__:__:__:__:__:__:__:__:__

Expiration date: ____/____
year month

WHO TO CALL IN CASE OF AN EMERGENCY:

PRIMARY CONTACT:	OTHER:
Name: _____	Name: _____
Home: _____	Home: _____
Work: _____	Work: _____
Cell: _____ (Circle first number to call.)	Cell: _____ (Circle first number to call.)
Relationship to student: _____	Relationship to student: _____

In order to ensure the security of the student, the school must be informed of any health problems that might require immediate intervention at school, such as a severe allergy to certain foods or insects, diabetes, etc.)

Does your child suffer from such a health problem? Yes (If yes, please complete page 2.)

No

PLEASE INFORM THE SCHOOL OF ANY CHANGES THAT MIGHT OCCUR DURING THE PRESENT SCHOOL YEAR.

The information contained in this form will only be transmitted to the school nurse and to school staff who may be required to assist the student in case of emergency.

_____ Date: _____
(signature of parent/guardian)

ADDITIONAL INFORMATION

(To be completed only if the student has health problems that might require immediate intervention at school.)

DOES THE STUDENT SUFFER FROM:

A SEVERE ALLERGY:

To food:	Yes	No	Please specify: _____
To insect bites:	Yes	No	
Other:	Yes	No	Please specify: _____
Medication:	Yes	No	Please specify: _____
Epipen:	Yes	No	
Other:	Yes	No	Please specify: _____

DIABETES:	Yes	No	
Medication:	Yes	No	Please specify: _____
In case of hypoglycaemia:	_____		

OTHER:

Does the student suffer from any other problem that might require immediate assistance at school?

Yes No Please specify: _____

_____

Medical recommendation in case of emergency:

_____

_____

I authorize the CLSC nurse to communicate the above information to the school staff who may be required to assist the student in case of emergency.

_____ Date: _____

(signature of parent/guardian)