

PLEASE NOTE: The Health Centre staff **will** provide routine immunization injections, as required by Ontario Health law, to keep your child's immunization record up to date.

Please complete the following health History:

1. Medical concerns, acute or chronic Diabetes, asthma, epilepsy, etc.:

2. Previous surgery/dates:

3. Regular medications taken and reason administered. Please indicate dosages clearly.

4. List any allergies and physical symptoms that occur.

5. Does your child have any psychological problems of which you are aware? If so, please elaborate, giving any particulars of counseling by Psychiatrists or any other medical personnel (ie. Clinical Psychologists or Stress Therapists).

6. Does your child wear glasses or contact lenses? (Please specify)

7. Check and give dates if your child has had any of the following diseases:

Chicken Pox	Scarlet Fever	Whooping Cough
Hepatitis	Rheumatic Fever	Red Measles
Mononucleosis	German Measles	Pneumonia
Tonsillitis	Tuberculosis	Other:

DENTAL:

Family Dentist: _____ Orthodontist: _____

Tel #: _____ Tel #: _____

Last check-up: _____ last check-up: _____

CONSENT FOR DENTAL TREATMENT: Emergency only: Yes _____ No _____
All treatment: Yes _____ No _____
(6 mo. /exam)

PLEASE READ THE FOLLOWING BEFORE SIGNING

The permission I have indicated in this form, after proper completion, is valid for my child's ENTIRE STAY at Albert College unless I request a specific change.

I WILL NOTIFY the school Health Centre immediately of any current medical problems or injuries which arise during the course of any stay at home, especially after any school vacation, as it is essential that his/her medical record be kept up-to-date.

In the event of my son/daughter requiring emergency medical treatment, as recommended by a physician, I give permission for the Health Centre or Head of School to authorize such treatment.

In emergency situations, please attempt to contact me, but if this is not possible, you may contact:

Name: _____ Name: _____

Address: _____ Address: _____

Home Number: _____ Home Number: _____

Work Number: _____ Work Number: _____

Fax Number: _____ Fax Number: _____

E-Mail Address: _____ E-Mail Address: _____

Relation to Student: _____ Relation to Student: _____

PERMISSION IS GRANTED FOR TESTS, TREATMENT, AND EMERGENCY care of my child to the extent that I have indicated.

Signature (Parent/Guardian)

Date