



MEDICAL HISTORY FORM

Name of Student: _____ Health Card #: _____

Student's Physician: _____ Phone#: _____

Does your child have any serious medical conditions that we should be aware of?

Has your child had his/her eyes tested? _____ Results: _____

Has your child has his/her hearing tested? _____ Results: _____

Does your child have frequent colds? _____ Stomach aches? _____ High fevers? _____

Does your child have any allergies? _____ Foods? _____ Animals? _____

Insect Bites? _____ Medications? _____ Asthma? _____

Briefly explain child's reaction to any of these allergies: _____

What counter measures need to be taken should a reaction occur? _____

Is your child receiving any medication on a continuous basis? _____

If so, name? _____ Reason? _____

Please list the dates your child received the following immunizations:

DTP1 _____ DTP1 _____ DTP1 _____ DTP1 _____ DTP1 _____

MMR _____ HIB _____ TB _____ TB _____

Signature of Parent: _____

Date: _____

This application form is the initial form required to supplement registration for potential applicants. Please be aware further documentation will be required before matriculation. Personal information is collected under the legal authority of the Education Act, R.S.O. 1980, c. 129. This information will be used for the purposes of: processing student registration, production of student databases, student placement and referrals, statistical and reporting requirements by the Ministry of Education, program development, determining transportation requirements, creation and maintenance of the Ontario student records, provision of provincially funded health resources to students, contracting parent(s), etc., in case of emergency, and the disclosure of health related information to the Medical Officer of Health. Questions regarding this collection and use of personal information should be directed to the School Office.