Northeastern
Catholic District
SCHOOL BOARD

STUDENT MEDICAL INFORMATION

This information will be used to ensure adequate medical supervision for any overnight excursion.

STUDENT'S NAME: _____ HOME TEL. # _____

DOCTOR'S NAME: _____ DOCTOR'S TEL. #_____

1. Does the student have a serious medical condition (epilepsy, heart, asthma, etc.)? Yes ☐ No ☐
   If yes, please identify.
   _____

2. Does the student take any type of medication? Yes ☐ No ☐
   If yes, name of medication and dosage.
   _____

3. Does the student need a special diet for medical reasons? Yes ☐ No ☐
   If yes, please specify.
   _____

4. Is the student dependent on eye glasses/contact lenses for normal activity? Yes ☐ No ☐

5. Are there any activities the student should not participate in for medical reasons? Please describe.

6. Are there any special cautions for the student as a result of his/her medical condition?

7. Please add any other information which could be useful should a medical emergency arise.

I confirm the above information to be accurate and I will ensure that the school has the required medication to ensure my child's health and well-being.

Signature of Parent: _____ Date: _____

The legal authority for the collection of this information is the Education Act. The Board uses the information for the purpose of carrying out its responsibilities under the Act. If you require clarification about the collection of this information, contact the Privacy Information Officer at 705-268-7443.

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