

MEDICAL INFORMATION (OFFICE USE ONLY)

Section 2(1)(p) of the Student Record Regulation any health information the parent of a student or the student wishes to be placed on the student record.

Student's Name: _____

Age: _____ Grade: _____ Gender: _____

Home Room Teacher: _____

Parents' Names: _____

PHOTO

Home Telephone: _____

Work Telephone: _____

Cell Telephone: _____

Emergency Telephone: _____

Doctors Name & Telephone: _____

Alberta Health Care #: _____

(This information is optional and will only be used for obtaining emergency medical care.)

Are you currently a participant in the "No Child Without" program? (MedicAlert)

No Yes If yes please explain medical conditions:

Other Medical Conditions:

Procedure in Case of Emergency:

I voluntarily consent to St. Albert Catholic Schools using my/my child's photograph, name and medical information in the school staff room as well the school would create a small card for our supervisors to carry when they are on supervision. By signing this consent form below, I am stating that I understand the purpose for using my/my child's information is for all staff to be aware of his/her medicals concerns.

X

Parent/Legal Guardian
or Independent Student

Date

