

Toronto District School Board

Medical Information for Excursions

The collection and retention of the information requested on this form is authorized and governed by the Ontario *Education Act* and the *Municipal Freedom of Information and Protection of Privacy Act*.

Please print carefully and legibly.

The following information will be helpful to the teacher in making your child's/ward's excursion more comfortable, safe and pleasant.

Student Name: _____ Grade/Program: _____ Teacher: _____
Address: _____ Date of Birth: _____
Parent/Guardian name: _____ Telephone: (H) _____ (B) _____
Parent/Guardian name: _____ Telephone: (H) _____ (B) _____
Ontario Health Number: _____ Family Doctor: _____ Telephone: _____

MEDICAL CONDITIONS

(1) Does your child/ward suffer from any medical conditions, physical handicaps or disabilities of which the school should be aware? _

(2) Can your child/ward participate fully in the school excursion? Yes: _____ No: _____.

If not, please explain: _____

(3) Please check off any significant medical conditions, physical limitations or any other concerns which might affect your child/ward's full participation in the excursion, and give details of usual treatment

- Migraine Headaches: _____
- Fainting Spells: _____
- Urinary Infections: _____
- Ear, nose, throat infections: _____
- Sleepwalking: _____
- Digestive Upsets: _____
- Haemophilia: _____
- Chronic Nosebleeds: _____
- Diabetes: _____
- Asthma: _____
- Epilepsy: _____
- Feet or Legs: _____
- Heart: _____
- Rash: _____
- Recent illness or operation: _____
- Rheumatic fever: _____
- Dislocated shoulder; hernia; swollen, hypermobile, or painful joints; "trick or lock" knee, or any other disability: _____
- Other: _____

ALLERGIES/ASTHMA

Please list all known confirmed allergies to the following:

- (a) Foods: _____
- (b) Medications: _____
- (c) Other (e.g., bee stings, environmental allergies): _____

Has your child/ward suffered a serious allergic or asthmatic reaction? If so, please provide details, including the type and severity of reaction: _____

Has a doctor prescribed an Epi-Pen for your child/ward? Yes: _____ No: _____

Has a doctor prescribed an asthma inhaler for your child/ward? Yes: _____ No: _____

MEDICATION

(1) Give date of last tetanus shot: _____

(2) Does your child/ward take prescribed medication on a regular basis? Yes: _____ No: _____ Please specify: _____

(3) What prescribed medication(s) should the participant have on hand during the excursion? _____

GENERAL

(1) Does your son/daughter/ward wear or carry medical alert identification (e.g., bracelet) _____

If yes, please specify what is written on it: _____

(2) Does your child/ward have any other relevant medical condition that will require modification of the program: _____

(3) If your child/ward has any special night-time fears or conditions, (e.g., bed-wetting, nightmares), knowledge of which will allow the teacher to make the student's visit more relaxed, please state: _____

DIETARY RESTRICTIONS

Please list any foods the student should not eat for medical, dietary or religious reasons. If foods are life-threatening, explain the symptoms and the treatment: _____

Should it become necessary for my/our child/ward to have medical care, I/we hereby give the teacher permission to use her/his best judgment in obtaining the best of such service for our child/ward. We understand that any cost will be our responsibility. We also understand that in the event of illness or accident, we will be notified as soon as possible.

Date: _____

Name of Parent/Guardian: _____
(printed name of parent/guardian)

Signature of parent/guardian: _____
(or student if 18 years or older)