SPHEReS
School Physical Activity, Health & Education Resource for Safety

Medical Information Form

The information collected below will be protected and used in compliance with the Freedom of Information and Protection of Privacy (FOIPP) Act.

Name of Student _____ **Date** (dd / mm /yyyy) _____/_____/_____

Age _____ **Sex** _____ **Gender** _____ **Grade** _____ **ID No.** _____

School _____ **Health #** _____

Family Physician _____ **Phone** _____

Emergency Contact _____ **Phone** _____

I would like to inform the school about these facts pertaining to my child's physical / medical condition related to his/her participation in Physical Education Curricular and Intramural Programs.

Please indicate (check the box) if your son / daughter / ward has been subject to any of the following and provide pertinent details:

- ☐ anemia
- ☐ epilepsy
- ☐ diabetes
- ☐ orthopedic problems (e.g.: knee)
- ☐ cardiovascular conditions (heart / blood pressure)
- ☐ concussion
- ☐ asthma / allergies
- ☐ head or back conditions or injuries (past 2 years)
- ☐ arthritis or rheumatism
- ☐ chronic nosebleeds
- ☐ dizziness
- ☐ fainting
- ☐ headaches
- ☐ dislocated shoulder
- ☐ hernia
- ☐ swollen, hyper-mobile, or painful joints

Details:

SPHEReS
School Physical Activity, Health & Education Resource for Safety

Medical Information Form

MEDICATIONS:

What medication(s) should the student have on hand during activity?

Who should administer the medication?

☐ I, the parent/guardian, give permission for the teacher to administer this medication(s) to the student as directed or needed.

OR

☐ Although the student can under normal circumstances administer his/her own medication, I, the parent/guardian, give permission for the teacher to administer the medication if an injury/illness prevents the student from doing so themselves.

Signature _____ Date _____

Does the student wear a Medic Alert™ bracelet □, neck chain □, or a Medic Alert™ card □?
□ YES □ NO

Does the student wear eyeglasses or contact lenses?
□ YES □ NO Specify:

Other relevant medical condition(s) that will require modification of the program, or specific activities that the student should not participate in (please provide medical reason):

I acknowledge that the information I have provided is correct and give consent to the school to use the above information for the purposes described above for the 20__-20__ school year.

Signature _____ Date _____

FREEDOM OF INFORMATION NOTICE

The information provided on this form is collected pursuant to the Board's education responsibilities as set out in the School Act and its regulations. This information is protected under the Freedom of Information and Protection of Privacy Act and will be utilized only for the purposes related to the Board's Policy on Risk Management. Any questions with respect to this information should be directed to your school principal.