

Kemptville Pentecostal Church

1964 County Rd 43, Kemptville, ON K0G 1J0



Medical Information Form

Students Full Name: _____ DOB: _____ Grade: _____

Parent/Guardian: _____ Relationship to Child: _____

Telephone: (H)(____) _____ © (____) _____ Email: _____

Additional Contact (in the event that you are unavailable): - MUST HAVE A SECOND CONTACT

Name: _____ Relationship to Student: _____

Telephone: (H)(____) _____ © (____) _____ Email: _____

Medical Conditions/Information provided on this form will be used to make decisions concerning your child's health during the activity/excursion, information in not intended to limit level of participation.

**Please check all that apply to your child*

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Rash
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Feet or Leg Problems	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	Chronic Nosebleeds	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Digestive Upsets	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Sleepwalking
<input type="checkbox"/>	Drug Sensitivity	<input type="checkbox"/>	History of Head Injuries	<input type="checkbox"/>	Urinary Infections
<input type="checkbox"/>	Ear/Nose/Throat Infection	<input type="checkbox"/>	Recent Illness or Operation	<input type="checkbox"/>	Dislocated shoulder
<input type="checkbox"/>	Swollen/Painful Joints	<input type="checkbox"/>	Joint Disability	<input type="checkbox"/>	Recent Concussion

Other:

List any and all medications and their treatment below:

Give details of history/usual treatment for each of the above conditions indicated above:

Please explain if your child has any other medical condition/treatment that we should be aware of:

Allergies/ Asthma

Has your child suffered any serious allergic or asthmatic reaction? _____

Explain what happened (symptoms, treatment): _____

If YES, please provide details, including the type and severity of reaction:

Mild: _____ Moderate: _____ Serious: _____ Life-Threatening: _____

Has your doctor prescribed an **Epi-Pen** for your child? Yes _____ No _____

Has your doctor prescribed an **inhaler**? Yes _____ No _____

****Prescribed asthma inhalers and Epi-Pens MUST be carried by the student on the excursion and MUST NOT be expired.**

I, _____ confirm the information above is the most up to date medical information.

Signature of Parent/Guardian: _____ Date: _____

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

Name of Parent: (Print name) _____

Signature of Parent/Guardian: _____ Date: _____