Kemptville Pentecostal Church

1964 County Rd 43, Kemptville, ON K0G 1J0

Medical Information Form

Student's Full Name: ______________________________ **DOB:** _______________ **Grade:** ________

Parent/Guardian: _________________________________ **Relationship to Child:** _________________

Telephone: (H)(____)___________ (C) (____)___________ **Email:**______________________________

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

Name: _________________________________ **Relationship to Student:** ________________________

Telephone: (H)(____)___________ (C) (____)___________ **Email:**______________________________

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

Please check all that apply to your child

	Asthma		Fainting Spells		Rash
	Allergies		Feet or Leg Problems		Migraines
	Chronic Nosebleeds		Bleeding Disorders		Rheumatic Fever
	Diabetes		Heart Problems		Seizures
	Digestive Upsets		Hernia		Sleepwalking
	Drug Sensitivity		History of Head Injuries		Urinary Infections
	Ear/Nose/Throat Infection		Recent Illness or Operation		Dislocated Shoulder
	Swollen/Painful Joints		Joint Disability		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:** ___________