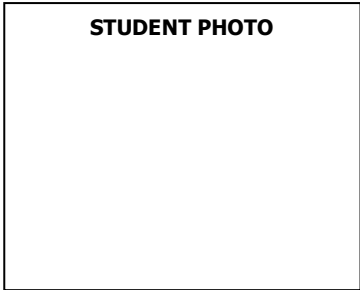


# EVERGREEN ACADEMY INC. STUDENT MEDICAL PROFILE



## STUDENT IDENTIFICATION

Last Name:	First Name:	Middle Name:		
Address:	City:	Postal Code:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Home Phone:	Cell Phone:	Date of Birth:		

## FAMILY INFORMATION

Mother's Name:	Cell Phone:	Email:
Father's Name:	Cell Phone:	Email:

## EMERGENCY CONTACT INFORMATION

Last Name	First Name:	Relationship to Child:	Phone:
Last Name	First Name:	Relationship to Child:	Phone:
Last Name	First Name:	Relationship to Child:	Phone:

## MEDICAL INFORMATION

Family Physician:	Address:	Phone:
Dentist/Orthodontist:	Address:	Phone:
Ophthalmologist:	Address:	Phone:

## HEALTH CARD

Health Card Number:	Version Code:
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## OTHER HEALTH INSURANCE

Name of Carrier:	Policy Number:	Name of Drug Insurance Plan:
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## ALLERGY INFORMATION

Does the student have any allergies that we should be aware of? If yes please provide details.

YES  NO

Please note that if an epinephrine auto injector is required you will need to complete a Severe Allergy Alert Form, and a Consent Form for Epinephrine Injection and Transport to Hospital



**ACKNOWLEDGEMENT**

Consent to Treatment:

I am the parent/legal guardian of \_\_\_\_\_(student name), and hereby give my consent to Evergreen Academy Inc. to provide medical treatment, if deemed necessary by Evergreen staff, while my child is in attendance.

I hereby agree that the relationship and the resolution of any and all disputes arising therefrom between myself and/or \_\_\_\_\_(student name) and the staff at Evergreen Academy Inc. shall be governed by and construed in accordance with the laws of the Province of Ontario.

I hereby give my consent to the staff at Evergreen Academy Inc. to provide or arrange for the provision of any necessary or emergency medical treatment for \_\_\_\_\_(student name) as they may deem appropriate and whether such medical treatment is provided at Evergreen Academy Inc, or other medical or health care facility.

I hereby consent to the release of any and all medical records concerning \_\_\_\_\_(student name), by the staff at Evergreen Academy Inc. to another medical or health care facility that is required to provide medical treatment to such student.

I hereby acknowledge that the medical information I have provided is correct and complete. I agree to notify Evergreen Academy Inc. of any medical development in the health of \_\_\_\_\_(student name) while in attendance at Evergreen Academy Inc.

Parent/Guardian Signature:	Printed Name:	Date:
Witness Signature:	Printed Name:	Date: