HEALTH AND SAFETY INFORMATION

SEPTEMBER – JUNE

The Academy for Gifted Children - P.A.C.E.

Name of Child: _____ Height: _____ Weight:_____Gender:_____Grade:_____

Address: _____Home Tel#_____ Date of Birth:__d – m - y_____

Ontario Health Card Number:_____ Family Doctor :_____Doctor's Tel #:_____

Emergency Contact Name/Relationship/Tel. Number: you give full authority over your child (please print) _____

Mother's Name: please print _____ Bus. #:_____Cell #:_____

Father's Name: please print _____ Bus. #:_____Cell #:_____

All information will be held in the strictest confidence. Does your child have any of the following? (if yes, please elaborate on reverse)

❑ Diabetes ➔ Medical Alert Bracelet Yes ❑ No ❑ Medication(s) Yes ❑ (see reverse) _____ No ❑
(signature for consent to administer if needed)

❑ Epilepsy ➔ Medical Alert Bracelet Yes ❑ No ❑ Medication(s) Yes ❑ (see reverse) _____ No ❑
(signature for consent to administer if needed)

❑ Heart Concerns ➔ Medical Alert Bracelet Yes ❑ No ❑ Medication(s) Yes ❑ (see reverse) _____ No ❑
(signature for consent to administer if needed)

❑ Migraines ➔ Medication(s) Yes ❑ (see reverse) _____ No ❑
(signature for consent to administer if needed)

❑ Recent illness or operation _____ ❑ Any other medical concerns _____

ALLERGIES please circle (food, drugs, insects, environmental, other) _____

What are the signs/symptoms your child exhibits when he/she comes in contact with allergen?_____

Is allergy considered: Mild____ Moderate____ Serious____ Life-Threatening____

Has a doctor prescribed an EPIPEN?
Yes ❑ (please attach individual management plan) No ❑
(you MUST provide **2 epipens**; one the child must carry, the other will be stored in the main office)

I acknowledge that the epipen will be administered to my child should the school deem it necessary. X Signature of Parent/Guardian

ASTHMA Yes ❑ (please attach individual management plan)

Does your child require a puffer?

Yes ❑ (you MUST provide **2 puffers**; one the child must carry, the other will be stored in the main office).

No ❑

Please complete the record below or enclose a copy of your child's immunization record and return it to the school.

Vaccine Dates Given (yy/mm/dd)	Diptheria	Tetanus	Pertussis	Polio-IPV	Polio-OPV	Hib	Pneumo conjugate	Measles	Mumps	Rubella	Men-C conjugate	Varicella	Hepatitis B

Should it become necessary for my child to receive medical care, I hereby give the school, The Academy for Gifted Children – P.A.C.E., permission to use its best judgment in obtaining the best of such service for my child. I understand that any cost will be my responsibility and that in the event of illness or accident, I will be notified as soon as possible. I also understand that it is my responsibility to ensure that the information on this form is kept current and as such, I will notify P.A.C.E. immediately of any changes to my child's medical information.

Name of Parent/Guardian (please print) _____ **Signature of Parent/Guardian** _____ **Date** _____