QUESNEL SCHOOL DISTRICT
ATTACHMENT 'E' – POLICY 445 –
OUT-OF-SCHOOL LEARNING EXPERIENCES

OUT-OF-SCHOOL LEARNING EXPERIENCE MEDICAL FORM

To be completed by Parent or Guardian

Out-of-school learning experiences to: _____ Date: _____

Student's Name: _____

MEDICAL INFORMATION

Name Of Family Doctor: _____ Phone: _____

Care Card No.: _____

Date of most recent immunization against tetanus, if known: _____

Known sensitization (allergies) if any: _____

Chronic disability or illness (past or present): _____

Does the student have any health issues we should be aware of? _____

Please describe: _____

_____

DIETARY RESTRICTIONS:

Describe: _____

MEDICATIONS:

I would like my child to be given the following medications:

Name of medicine: _____ What is it to be used for: _____

How is it to be given: _____

Quantity to be given: _____ Times to be given: _____

Medicine should be clearly labeled with the child's name, name of medication, what it is to be used for, quantity to be given and time to be given. In case of emergency, I hereby give permission to the physician named above, or, in their absence, to any other physician, to provide treatment for my child.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Parent's/Guardian's Home Phone Business Phone (if applicable)

Emergency number and/or contacts: _____

Adopted: February 2008
Amended: February 2005
Reviewed: September 2016