Athol Murray College of Notre Dame

Student Health Information

2012 - 2013

(to be completed by parent/legal guardian – please print clearly)

Name: ____ **DOB:** ______/______/_____
Last Name Official First and Second Names Year Month Day

Family Physician: ____ **Number of Years:** _________

Address: ____

____ **Phone Number: (   )** ____________

Hospital/Medical Insurance:

Provincial Health Card Number: _______________________________ **Province**: ______________________________

***** A clear photocopy of the student's provincial health card must accompany this form*****

First Nations Treaty Number: ______________________________ DIAND Number: ________________________________

Band Name & Number: ____

Allergies: Yes ______ No ______ If yes, please describe ____

____

Asthma: Yes ______ No ______ If yes, please describe ____

____

Tobacco Use: smoking ______ chewing ______ How long? ______

Dental/Orthodontic History: ____

____

Vision: Does your child wear: contacts ______ glasses ______

Immunizations:

***** An official copy of the student's immunization record must be attached to this form*****

This record must include their most recent immunizations and may be obtained from your Department of Health, school or family physician.

I authorize and hereby consent to immunization to be given should it be deemed necessary. Yes _______ No ______

Hospitalizations: Yes ______ No ______ If yes, please describe ____

____

____

Counseling:

Has the student currently, or in the past, received counseling? Yes _____ No _____

If you answered yes, you are required to provide the most recent evaluation. Written consent must be provided allowing the College's Nurse to contact the counselor or medical professional regarding the student's diagnosis, treatment and on-going care.

Please provide information regarding any physical, emotional or mental condition that the student may have experienced. This information is vital for the student's success at Notre Dame.

____

____

Has the student ever received any treatment or counseling for addictions? Yes _____ No______ Inpatient ______ Outpatient _____

If yes, you MUST provide the most recent evaluation from their treatment center/addictions counselor. Written consent must be provided allowing the College's Nurse to contact the counselor or doctor regarding the student's assessment, treatment and/or after-care program.

Medications:

Is your child taking any medication(s): Yes _________ No ________

Current Medications:

NAME	PRESCRIPTION	OVER THE COUNTER	DOSE & FREQUENCY	REASON FOR TAKING

In Case of Emergency if parent or legal guardian cannot be reached, please contact:

______________________________ ______________________________
Name Relationship to the Student

____
City Prov/State Country

( ) ______________________________ ( ) ______________________________
Telephone Number Cell Number

It is the policy of the college to contact parents/legal guardians at the earliest opportunity in the event of serious illness or injury.

AUTHORIZATION, RELEASE, AND INDEMNITY

To the best of my knowledge, the information I have provided is accurate and complete.

I understand and acknowledge that the staff officers, employees and agents of Athol Murray College of Notre Dame act in place and position of a parent or guardian of my child while my child is in attendance at the College. Recognizing this, I authorize each or any of them to provide my child with medical treatment that they consider to be reasonable or necessary during the time period my child is in attendance at the school.

In consideration of their willingness to care for my child, I release, remise and discharge, employees and agents from any and all liability, claims or causes of action which may arise, by virtue of the application, or non-application of medical treatment.

Dated at__________________________________, **in the Province/State of**__________________________,

this__________ **day of** ______________________, **A.D. 20**_________.

______________________________ ______________________________
Signature of Parent/Legal Guardian Name of Parent/Legal Guardian ***(please print)***

______________________________ ______________________________
Signature of Parent/Legal Guardian Name of Parent/Legal Guardian ***(please print)***