



MEDICAL INFORMATION

NAME OF STUDENT: _____ DOCTOR'S NAME: _____

GRADE: _____ DOCTOR'S ADDRESS: _____

STUDENT'S HEALTH INSURANCE NUMBER: _____

It is extremely important that the School is aware of any medical problem that a student may have, or of any medication which is required by a student. If this applies to your daughter, please describe her treatment in the space provided below.

The Linden School is a NUT –FREE environment. Knowing that there are students who have food allergies, sometimes severe, we request that absolutely NO nuts or nut products be included in student lunches or snacks.

- It is the responsibility of each family to inform the school on this medical information form about any allergies.
- This information will be communicated to the girl's teachers and will accompany her on any field trips.
- We ask parents to teach their daughters to ask about ingredients which may be harmful to her.
- We request your help in ensuring that The Linden School remains a perfume-free environment.

Does your daughter have allergies? YES___ NO___

If YES, to what is she allergic? _____

Please describe the type of reaction _____

I have advised my daughter to inform an adult when she begins to experience an allergic reaction.

List medical devices or drugs (must be prescribed by a doctor) which student will bring from home, i.e. Epi –pen, inhalation medication, and state where student will store or carry them: _____

My daughter knows how to use a _____

Has your daughter had hepatitis? YES___ NO___ If YES, describe the illness _____

Does your daughter have a vision problem? YES___ NO___

Does your daughter wear glasses? YES___ NO___

Does your daughter have a hearing problem? YES___ NO___

Does your daughter wear a hearing aid? YES___ NO___

PTO

Immunization Information

The *Immunization of School Pupils Act 1982* makes it mandatory for all schoolchildren to be immunized against Diphtheria, Tetanus, Poliomyelitis (DPT), Measles, Mumps and Rubella (German Measles) (MMR). Pertussis immunization, although not mandatory, is recommended and is often included with Diphtheria, Tetanus and Polio (DPTP).

Please complete the following **OR** attach a photocopy of your daughter's records for the following:

Diphtheria-Pertussis-Tetanus-Polio (DPTP) or Measles-Mumps-Rubella (MMR)

	Day	Month	Year
DPTP/DPT/Haemophilus B/Pneumococcal (at 2 mo)	___	___	___
DPTP/DPT/Haemophilus B/Pneumococcal (at 4 mo)	___	___	___
DPTP/DPT/Haemophilus B/Pneumococcal (at 6 mo)	___	___	___
MMR/Meningococcal (12 mo)	___	___	___
Pneumococcal/Chicken Pox (15 mo)	___	___	___
DPTP/Haemophilus B/MMR (booster at 18 mo)	___	___	___
DPTP (booster 4-6 yrs)	___	___	___
Meningococcal/Hep B (12 yrs)	___	___	___
DPT (14-16 yrs)	___	___	___
Every Autumn (Influenza)	___	___	___

Tuberculin Skin Test Given: YES___ NO___ Day___ Month___ Year___

If YES Negative___ Positive___

*For further information, please consult the Toronto Public Health website at <http://www.toronto.ca/health/>

In the event of an emergency, the school is authorized to request emergency treatment.

I, _____(Parent/Guardian) hereby consent to the disclosure of health information which will enable the school personnel to meet my child's needs.

Signature of Parent/Guardian

Date

TYLENOL DISPENSATION

I, _____(Parent/Guardian) have consulted with my family doctor and hereby give my consent for my daughter _____ to be given Tylenol during the school day, should she request it.

Signature of Parent/Guardian

Date