2010-2011

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 <u>NUT –FREE environment</u>. Knowing that there are students who have food allergies, sometimes severe, we request that <u>absolutely NO nuts or nut products</u> 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

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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		Day	Month	Year
DPTP/DPT (at 2mo)				MMR (12mo)			
DPTP/DPT (at 4mo)				Measles(if separate)			
DPTP/DPT (at 6mo)				Mumps (if separate)			
DPTP/DPT (booster at 18mo)				Rubella (if separate)			
DPTP/DPT (booster 4-6 yrs)							
TdP (Tetanus, Diphtheria, Polio 14-16 yrs)							
Haemophilus Influenza (HIB) (Meningitis)							

Tuberculin Skin Test Given: YES NO

If YES Negative Positive Day Month Year

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.

Parent/Guardian Name: Date:

*Note: entering you name above is equivalent to a signature for the purposes of this form.

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.

Parent/Guardian Name: Date:

*Note: entering you name above is equivalent to a signature for the purposes of this form.