

STUDENT MEDICAL CONSENT

Name of child: _____ Male Female

Birth date (m) _____ (d) _____ (y) _____. **BC Care Card Number** _____.

Child's School : _____ Dates Attending: _____ to _____ 20__

_____ Medical Information _____

- 1) I give permission for my child to be given Tylenol and/or Advil if needed: (parent's signature) X _____
(Please supply if your child is likely to use this)
- 2) I give permission for my child to be given Gravol if needed: (parent's signature) X _____
(Please supply if your child is likely to use this)
- 3) Date of most recent tetanus immunization: _____
- 4) Chronic disability or illness: _____
- 5) Known sensitivities/allergies or restrictions (please complete food allergies and special diets on reverse): _____

- 6) Other medical conditions staff should be aware of (i.e. bed wetting, sleep walking, night terrors, migraines etc.) _____

_____ Prescribed Medications _____

I request and authorize my child's teacher, Cheakamus Centre staff or a qualified first aid person to administer the following medications prescribed by **Dr.** _____, **Phone #** _____ as indicated below:

Name of medicine: _____	Name of medicine: _____
What it is to be used for: _____	What it is to be used for: _____
How it is to be given: _____	How it is to be given: _____
Quantity to be given: _____	Quantity to be given: _____
Times to be given: _____	Times to be given: _____

- Medicines must be clearly labelled with the child's name, name of medication, what it is to be used for, quantity to be given, and times to be given. Additional information attached.
- Please contact Program Support Specialist with any concerns & additional information • 1-604-898-5422 ext.232
email: odsclinic@sd44.ca

This section Must be Filled out Completely _____

Name of parent (guardian): _____ Name of parent (guardian): _____

Address: _____ Postal Code: _____

Home Phone #: _____ Cellphone #: _____ Work Phone#: _____

If I cannot be contacted in the event of an emergency, please contact

Name Emergency Contact: _____ Home Phone # _____ Cellphone #: _____

Cheakamus Centre staff (which includes the Board of Education of School District No. 44 (North Vancouver) and its employees, agents, contractors, representatives and volunteers) administer medication as directed above. To the best of their ability they: 1) administer the medications as prescribed; 2) treat reactions to prescribed medication if they occur; 3) store medication in a secure location and handle it as directed. In consideration of Cheakamus Centre staff taking on this role voluntarily, I forever discharge Cheakamus Centre staff and the Board of School Trustees of District # 44 from all actions and demands relating to administration of prescribed medications.

In case of emergency, I hereby give permission to the physician selected by Cheakamus Centre staff to provide treatment for my child.

Parent's signature: X _____ Date: _____

Please TURN OVER, review and sign the back of this form

FOOD ALLERGY AND SPECIAL DIET FORM

In order to satisfy your child's dietary requirements, please fill out Allergy Section entirely and the relevant sections that follow as completely as possible. You may add additional information as needed. Please note that this is for allergies and special diets only, not for dislikes.

Name of child: _____ Male Female

School Attending: _____ Dates Attending: _____ to _____

Food Allergies

My Child has NO food Allergies Correct > go to next section

My Child is Allergic to _____ / _____ / _____

Trace amounts okay? Yes No

In baking okay? Yes No

Life Threatening? Yes No

Epi Pen Required? Yes No

Okay if label states that product "May contain trace amounts" of product? Yes No

Okay if label states "Made in a factory that uses" product? Yes No

Medications sent in case of contact (also fill out reverse section "Medications") Yes No

Lactose Intolerance

My Child has **NO** Lactose Intolerance Correct > go to next section

Small amounts okay? Yes No

Dairy in baking okay? Yes No

Cheese okay? Yes No

Ice Cream okay? Yes No

*Please note we have milk alternatives (rice, soy)

Other Special Diets

My Child has NO other Special Diet restrictions Correct > please sign below

Lacto ovo vegetarian (no meat or fish, but eggs and dairy are okay) Yes No

Lacto vegetarian (no meat, fish or eggs, but dairy is okay) Yes No

Vegan (no meat, fish, eggs, dairy or animal product: honey, gelatin etc) Yes No

Pescatarian (no meat but fish, eggs and dairy are okay) Yes No

Gluten free (no wheat products or ingredients with gluten) Yes No

Celiac disease Yes No

Other (please handwrite below) see below

Additional food you will send to supplement diet: _____

Other dietary restrictions and additional comments: _____

Parent's Signature: _____ Date: _____