MEDICAL UPDATE FORM

Return this form to the office ONLY
If your child has a medical condition.

Student's Last Name:	**Birthdate:** **Month / Day / Year**	**Student#** **----------** **Grade:**
Student's First Name:	**Care Card #**	
Emergency Contact #1 / Relationship: *(Please print name in this box)* _____/_____ **Email address:**	**Home#** **----------** **Cell#** **----------** **Work#**	
Emergency Contact #2 / Relationship: *(Please print name in this box)* _____/_____ **Email Address:**	**Home#** **----------** **Cell#** **----------** **Work#**	

Does your child have any of the following medical conditions which may require emergency care at school?

✔ Please check if applicable:	*Please list medications that your child is taking. A form needs to be filled out if you need our first aid or staff to help administer meds to your child.*
☐ **Severe Asthma**	**MEDICATIONS:**
☐ **Seizure – disorder / epilepsy**	
☐ **Life-threatening allergy (anaphylaxis)**	
☐ **Diabetes**	
☐ **Carries an Epipen**	
Other (Please specify):	

Is there anything the school staff needs to know about this condition?

In the event of a medical emergency at school, what action is necessary for the above condition?

Signature of Parent/Guardian:	**Date:**

The information on this form is collected under the authority of the School Act, Sections 13 and 97. This information will be used for education program and administrative purposes and, when required, may be provided to health services, social services or other support services as outlined in Section 97(s) of the School Act. The information will be protected under the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection or use of this information, please contact your school principal. ***CONFIDENTIAL***