Medical Form

NAME OF STUDENT _____ DATE OF BIRTH _____

NAME OF HOME PHONE _____

PARENT/GUARDIAN_____ WORK PHONE _____

IN CASE OF EMERGENCY CONTACT PARENTS NAME OF THE FAMILY DOCTOR

/OR _____PHONE _____ _____

OFFICE PHONE _____

HEALTH CARD NUMBER: Medical Insurance Plan No.:

A. **Please note any health problem, physical handicap, emotional difficulty, behavioural problem, or facts which may limit full participation in the classroom.**

B. **Student's immunization shots are current, i.e. tetanus and diphtheria, typhoid, smallpox, and polio vaccine** YES (__) NO (__) (PLEASE ATTACH UP TO DATE IMMUNIZATION RECORD)

C. **Student is subject to:**

__ asthma
__ ear ache
__ fainting
__ tonsillitis
__ eye infection
__ sensitive skin
__ sinus trouble
__ frequent colds
__ nightmares __ bronchitis
__ sleepwalking
__ convulsions
__ headache
__ bed wetting
__ kidney problem
__ nosebleed
__ high blood pressure
__ motion sickness
__ allergies (describe)

D. Student wears contact lenses

E. Special Diet _____

F. **Medications**: I would like my child to be given,

Name of Medication(s) _____

Purpose of Medication _____

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In case of emergency, I hereby give permission to the physician selected by the school or transport my child to a nearby emergency medical facility to provide necessary treatment for my child.
I understand that minor injuries or accidents will be treated on the school premises and that I will be notified of any such treatment.
In compliance with state regulations, I will pick-up my child as soon as possible in the event that Al-Manarat Heights calls to inform me that my child is ill.
I agree to inform Al-Manarat Heights immediately of communicable illnesses any of my family members contract even if they do not attend Al-Manarat Heights.

Parent/Guardian signature: _____ Date: _____