QUESNEL SCHOOL DISTRICT
ATTACHMENT 'E' – POLICY 445 –
OUT-OF-SCHOOL LEARNING EXPERIENCES

OUT-OF-SCHOOL LEARNING EXPERIENCE MEDICAL FORM

To be completed by Parent or Guardian

Out-of-school learning experiences to: _______________ Date: _________________________

Student's Name: ____

MEDICAL INFORMATION

Name Of Family Doctor: __________________________________ Phone: ______________

Care Card No.: ____

Date of most recent immunization against tetanus, if known: ___________________________

Known sensitization (allergies) if any: ____

Chronic disability or illness (past or present): ____

Does the student have any health issues we should be aware of? ________________________

Please describe: ____

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DIETARY RESTRICTIONS:

Describe: ____

MEDICATIONS:

I would like my child to be given the following medications:

Name of medicine: ____________________ What is it to be used for: __________________

How is it to be given: ____

Quantity to be given: ___________________ Times to be given: ______________________

Medicine should be clearly labeled with the child's name, name of medication, what it is to be used for, quantity to be given and time to be given. In case of emergency, I hereby give permission to the physician named above, or, in his or her absence, to any other physician, to provide treatment for my child.

____ ____________________________________

Signature of Parent/Guardian | Date

____ ____________________________________

Parent's/Guardian's Home Phone | Business Phone (if applicable)

Emergency number and/or contacts: ____

Adopted: February 2008
Amended: February 2005
Reviewed: September 2016