

**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: \_\_\_\_\_

**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 their 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