Emergency Health Record
2016-2017

LASALLE COMMUNITY COMPREHENSIVE HIGH SCHOOL

Name (student) : _____ School grade : _____

First name : _____ Class room number : _____

Address : _____ Language spoken at home : _____

Sex : F ☐ M ☐ Date of birth : _____ / _____ / _____
Year Month Day

Health insurance No : | | | | | | | | | | | | | Expiry date : _____/ _____
Year Month

Where you can be reached in case of emergency :

MOTHER	FATHER
Name : _____ First name : _____ ☎ home : _____ ☎ work : _____ ☎ other : _____	Name : _____ First name : _____ ☎ home : _____ ☎ work : _____ ☎ other : _____
OTHER	**OTHER**
Name : _____ First name : _____ ☎ home : _____ ☎ work : _____ ☎ other : _____	Name : _____ First name : _____ ☎ home : _____ ☎ work : _____ ☎ other : _____

In order to ensure the security of your child, the school must be informed of health problems that **might require immediate intervention** at school (severe allergy to food or insect bites, diabetes…).

Does your child suffer from such a health problem ? Yes ☐ If yes, complete the back of the sheet
No ☐

Please **inform the school of any change** that might occur during the present school year.

N.B. : The information contained in this sheet will only be transmitted to the school nurse and to the school staff who may be required to assist your child in case of emergency.

_____ Date : ____ / ____ / ____
Signature of parent, tutor or youth of 14 years or more Year Month Day

(Health Record Form)

Over ➔

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Additional information

(Fill only if your child has health problems that might require immediate intervention at school)

Has your child's state of health changed since last year : Yes ☐ No ☐

Does your child suffer from :

SEVERE ALLERGY :
- To food : Yes ☐ No ☐
- To insect bites : Yes ☐ No ☐
- Other Yes ☐ No ☐

If so, specify : _____
_____

Emergency medication : Yes ☐ No ☐ Épipen : Yes ☐ No ☐ Other : _____

DIABETES: Yes ☐ No ☐

Emergency medication : Yes ☐ No ☐ Specify ? : _____

Emergency care required, in case of hypoglycaemia, specify : _____
_____

OTHERS : Does your child suffer from any other problems that **might require immediate assistance** at school **?** Yes ☐ No ☐

If so, specify : _____

Medical recommendation in case of emergency : Yes ☐ No ☐

Specify : _____

I authorize the CLSC nurse to communicate the above information to the school staff that might be required to assist my child in case of emergency.

_____ Date : ____ / ____ / ____
Signature of parent, tutor or 14 years or more Year Month Day

(Health Record Form)