Surrey Schools

School District No. 36 (Surrey)

FIELD STUDIES MEDICAL FORM
FOR OUTDOOR AND/OR OVERNIGHT AND/OR OUT OF PROVINCE

Name of Student _____ Grade _____ Division _____
Care Card Personal Health No. _____ Date of Birth _____
Family Doctor _____ Phone No. _____

Name of Parent/Guardian _____
Address _____
Home Phone _____ Business Phone _____ Cell Phone _____

In case of emergency contact Parents/or:
Name _____ Phone No. _____

Please note any health problems, physical handicap, emotional difficulty, behaviour problem, or other factors which may limit full participation in this program. Use back of sheet if necessary. _____
_____
_____

Has the student had a previous injury which would require special first aid treatment should another injury occur? Explain. _____
_____

The student has received the regular immunization program administered in B.C. for diphtheria, pertusis and tetanus (DPT); tetanus and diphtheria (Td); polio; measles, mumps & rubella (MMR). Yes No (Circle)

Contact Lenses Yes No (Circle)

Child is subject to:

( ) asthma	( ) ear ache	( ) fainting	( ) tonsillitis	( ) frequent colds
( ) eye infection	( ) sensitive skin	( ) sinus problems	( ) seizures	( ) dislocations
( ) nightmares	( ) bronchitis	( ) high blood pressure	( ) nosebleeds	( ) pulled muscles
( ) headache	( ) bed wetting	( ) kidney problems	( ) dizziness	( ) sleep walking
( ) motion sickness	( ) sprains	( ) severe allergies	( ) other	

Please describe in detail any necessary information regarding the above medical problems: _____
_____
_____

Medications: All medicines should be clearly labelled with the child's name and information below. All medications must be controlled and in the possession of the first aider (except for allergies). Use back of form if additional space is needed to list medications.

Name of medicine _____ Used for _____

To be administered by _____ Quantity & Times _____

Permission granted by _____ Given how _____

In case of emergency, I hereby give permission to the physician selected by the educator-in-charge to provide necessary treatment for my child.

Parent/Guardian Signature _____ **Date** _____