ALEXANDER ACADEMY

688 West Hastings, Suite 200
Vancouver, British Columbia, V6B 1P1, Canada
Tel. 604-687-8832 Fax. 604-681-5898

MEDICAL FORM

Medical Alert ☐

STUDENT INFORMATION

First Name	Last Name (family name)
Date of Birth (YYYY/MM/DD)	Gender ◯ Male ◯ Female

MEDICAL INFORMATION

Please check all that apply. Attach related documentation.

Physical Considerations

- ☐ Hearing Impairment Specify: _____
- ☐ Visual Impairment Specify: _____
- ☐ Physical Impairment Specify: _____
- ☐ Other Specify: _____
- ☐ **None**

Medical Conditions

- ☐ Allergy Specify: _____
- ☐ Seizure disorder Specify: _____
- ☐ Diabetes Specify: _____
- ☐ Asthma Specify: _____
- ☐ Other Specify: _____
- ☐ **None**

Other Considerations

☐ Specialized learning needs Specify: _____

☐ Psychological condition Specify: _____

MEDICATIONS

☐ Yes Specify: _____

☐ **None**

MEDICAL INSURANCE

BC Medical Care Card Number	Family Doctor	Phone number
Private Medical Insurance Provider	Policy Number	Insurance Contact phone number

EMERGENCY CONTACT

Emergency Contact #1			
First Name	Last Name (family name)	Telephone	Relationship to Student
Emergency Contact #2			
First Name	Last Name (family name)	Telephone	Relationship to Student
Out of town Emergency Contact			
First Name	Last Name (family name)	Telephone	Relationship to Student

 Student Name: _____

IMMUNIZATIONS		
It is recommended that all children receive the following vaccines by age 14:		
Vaccine	**Vaccinated? Y / N**	**Date of Vaccination mm/dd/yyyy**
Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, and Haemophilus influenzae type b (DTaP-HB-IPV-Hib)	☐ ☐	
Chickenpox (Varicella)	☐ ☐	
Hepatitis B Vaccine	☐ ☐	
Human Papillomavirus (HPV)	☐ ☐	
Meningococcal C Conjugate (Men-C)	☐ ☐	
Tetanus, Diphtheria, Pertussis (Tdap)	☐ ☐	
Measles Mumps Rubella (MMR)	☐ ☐	
Pneumococcal Conjugate (PCV 13)	☐ ☐	
Rotavirus	☐ ☐	
Hepatitis A	☐ ☐	
Please attach a copy of the student's vaccination record		

I/we the parents, declare that the information contained in this application is accurate and complete to the best of my/our knowledge,

and

I/we the parents give consent to administer any medical treatment deemed necessary by a licensed physician and the transfer of my child to any hospital reasonably accessible. I understand and agree that Alexander Academy does not assume responsibility for any injury or damage which might arise out of or in connection with such authorized emergency medical treatment.

Signature of PARENT #1	Date
Signature of PARENT #2	Date