



## MEDICAL FORM

Medical Alert

### STUDENT INFORMATION

First Name	Last Name (family name)
Date of Birth (YYYY/MM/DD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

### MEDICAL INFORMATION

Please check all that apply. Attach related documentation.

Physical Considerations	Medical Conditions
<input type="checkbox"/> Hearing Impairment Specify: _____	<input type="checkbox"/> Allergy Specify: _____
<input type="checkbox"/> Visual Impairment Specify: _____	<input type="checkbox"/> Seizure disorder Specify: _____
<input type="checkbox"/> Physical Impairment Specify: _____	<input type="checkbox"/> Diabetes Specify: _____
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Asthma Specify: _____
<input type="checkbox"/> <b>None</b>	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> <b>None</b>

### 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

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)	Yes      No	
Chickenpox (Varicella)	Yes      No	
Hepatitis B Vaccine	Yes      No	
Human Papillomavirus (HPV)	Yes      No	
Meningococcal C Conjugate (Men-C)	Yes      No	
Tetanus, Diphtheria, Pertussis (Tdap)	Yes      No	
Measles Mumps Rubella (MMR)	Yes      No	
Pneumococcal Conjugate (PCV 13)	Yes      No	
Rotavirus	Yes      No	
Hepatitis A	Yes      No	
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