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KANEHSATÀ:KE TSI IONTHIATONHSERAWEIENHSTÀHKHWA

MEDICAL RECORD

DATE: / /

STUDENT IDENTIFICATION

LAST NAME	FIRST NAME	
ADDRESS	CITY	POSTAL CODE
TELEPHONE: CELL:	BIRTH DATE D M Y	MEDICARE NUMBER

FAMILY HISTORY

MOTHER'S MAIDEN NAME		FATHER'S NAME	
BROTHER'S NAMES	AGES	SISTER'S NAMES	AGES
STUDENT'S POSITION IN FAMILY		OF	

MEDICAL HISTORY

FAMILY DOCTOR	ADDRESS
TELEPHONE - -	CITY AND POSTAL CODE

ALLERGIES:	YES ☐	NO ☐
SEVERE ASTHMA-IMMIDIATE MEDICAL TREATMENT REQUIRED?	YES ☐	NO ☐
CAN THIS CHILD TAKE PART IN REGULAR PHYSICAL ACTIVITIES?	YES ☐	NO ☐
DOES CHILD HAVE TO TAKE MEDICATIONS?	YES ☐	NO ☐

IF YES, PROVIDE INFORMATION:

MEDICAL CONDITIONS AND SPECIAL MEDICAL INSTRUCTIONS:

COMMENTS RELATED TO MEDICAL PROBLEMS:

SIGNATURE: DATE:
(PARENT OF GUARDIAN)

IF IMPOSSIBLE TO REACH PARENTS

IN CASE OF EMERGENCY I AUTHORIZE THE SCHOOL AND/OR THE EDUCATION CENTER TO TAKE EMERGENCY MEASURES AND, IF NECESSARY, TO TRANSPORT, OR SECURE TRANSPORTATION FOR MY CHILD TO THE NEAREST MEDICAL FACILITY.

SIGNATURE: DATE:
(PARENT OR GUARDIAN)