

Toronto District School Board

Medical Information for Excursions

The collection and retention of the information requested on this form is authorized and governed by the Ontario Education Act and the Municipal Freedom of Information and Protection of Privacy Act.

Please print carefully and legibly.

The following information will be helpful to the teacher in making your child's/ward's excursion more comfortable, safe and pleasant.

Student Name: _____ Grade/Program: _____ Teacher: _____
 Address: _____ Date of Birth: _____
 Parent/Guardian name: _____ Telephone: (H) _____ (B) _____
 Parent/Guardian name: _____ Telephone: (H) _____ (B) _____
 Ontario Health Number: _____
 Family Doctor: _____ Telephone: _____

MEDICAL CONDITIONS

(1) Does your child/ward suffer from any medical conditions, physical handicaps or disabilities of which the school should be aware?

(2) Can your child/ward participate fully in the school excursion? Yes: _____ No: _____.

If not, please explain: _____

(3) Please check off any significant medical conditions, physical limitations or any other concerns which might affect your child/ward's full participation in the excursion, and give details of usual treatment

- Migraine Headaches: _____
- Fainting Spells: _____
- Urinary Infections: _____
- Ear, nose, throat infections: _____
- Sleepwalking: _____
- Digestive Upsets: _____
- Haemophilia: _____
- Chronic Nosebleeds: _____
- Diabetes: _____
- Asthma: _____
- Epilepsy: _____
- Feet or Legs: _____
- Heart: _____
- Rash: _____
- Recent illness or operation: _____
- Rheumatic fever: _____
- Dislocated shoulder; hernia; swollen, hypermobile, or painful joints; "trick or lock" knee, or any other disability: _____
- Other: _____

ALLERGIES/ASTHMA

Please list all known confirmed allergies to the following:

- (a) Foods: _____
 (b) Medications: _____
 (c) Other (e.g., bee stings, environmental allergies): _____

Has your child/ward suffered a serious allergic or asthmatic reaction? If so, please provide details, including the type and severity of reaction: _____

Has a doctor prescribed an Epi-Pen for your child/ward? Yes: _____ No: _____

Has a doctor prescribed an asthma inhaler for your child/ward? Yes: _____ No: _____

MEDICATION

- (1) Give date of last tetanus shot: _____
- (2) Does your child/ward take prescribed medication on a regular basis? Yes: _____ No: _____ Please specify: _____
- (3) What prescribed medication(s) should the participant have on hand during the excursion? _____

GENERAL

- (1) Does your son/daughter/ward wear or carry medical alert identification (e.g., bracelet) _____
If yes, please specify what is written on it: _____
- (2) Does your child/ward have any other relevant medical condition that will require modification of the program: _____
- (3) If your child/ward has any special night-time fears or conditions, (e.g., bed-wetting, nightmares), knowledge of which will allow the teacher to make the student's visit more relaxed, please state: _____

DIETARY RESTRICTIONS

Please list any foods the student should not eat for medical, dietary or religious reasons. If foods are life-threatening, explain the symptoms and the treatment: _____

SPECIFIC TO CAMP - MUSIC BY THE LAKE – June 2 – June 9, 2018

As a safety precaution for all campers, please note:

- If required by your child, asthma puffers and epinephrine pens should always be on your child's person. We recommend they wear a hip sack to hold these medications.
- Camp should not be used as an opportunity to remove or change the daily dosage of medicine. If your child takes medications at home and/or school, they must continue to do so at camp.
- I give permission for over the counter medications such as acetaminophen, throat lozenges, etc. to be administered to my child for minor medical issues such as headaches and sore throat.
- Any prescriptions sent to camp with your child must be in the original package with the prescribing physician's administering instructions clearly visible.
- With the exception of asthma puffers and epinephrine pens, all medications (prescriptions or other) must be stored and administered in the camp Medical Center. A nurse will be on duty 24 hours per day.

Should it become necessary for my/our child/ward to have medical care, I/we hereby give the teacher permission to use her/his best judgment in obtaining the best of such service for our child/ward. We understand that any cost will be our responsibility. We also understand that in the event of illness or accident, we will be notified as soon as possible. * If the child's parents live apart and if the camp is to act on behalf of both parents in an emergency situation, then both parents must sign below.

Date: _____

Printed name of Parent:

Signature of parent:

* If necessary:
Date: _____

Printed name of Parent:

Signature of parent:
