

A. MEDICAL INFORMATION

Student Name: _____ **Date of Examination:** _____

Health Card #: _____ **Status Card #:** (10 digits) _____

Expiry _____

For students who are sponsored by N.N.E.C., we need to ensure that all necessary medical information is provided so that we may provide supports as required.

Authorization for Release of Patients Information and Permission for Emergency Medical Treatment

I hereby authorize Sioux Lookout Meno-Ya-Win Health Centre, Thunder Bay Regional Health Sciences Centre, Sioux Lookout First Nations Health Authority (Nodin/Primary Health Care Unit-Northern Appointment Clinic), First Nations Family Physician Health Services or Health Canada to release the following information: any surgical, medical, including outpatient/clinic treatment, hospital admissions, and results of examinations or tests to:

Northern Nishnawbe Education Council, Box 1419, Sioux Lookout, Ontario P8T 1B9

From records of: _____

Name

D.O.B. (dd/mm/yy)

I understand that this information is to be used by the recipient for the purpose of ensuring proper medical care and follow up. On rare occasions, an emergency may arise requiring treatment in a hospital and/or surgery. In most cases, administration of an anesthetic, treatment of an injury or operation upon an individual cannot be done without consent of the patient (and/or parent/legal guardian). In order to prevent a dangerous delay in an emergency situation where N.N.E.C. is either unable to contact my parent or guardian, or if I am unconscious or otherwise unable to give my consent, I hereby authorize any N.N.E.C. delegated representative to secure whatever medical treatment is deemed necessary.

DATE: _____ **Expiry Date of Authorization:** _____

Signed by: _____

(student if over 18 or parent/legal guardian ONLY)

Signature of witness: _____

B: Student Medical Form

To: Medical Examiner:

Students entering secondary school should have a Health Examination by the community physician or Head Nurse. The Examination is to be recorded on this form.

FULL NAME OF STUDENT: _____

ADDRESS: _____

PARENT/GUARDIAN NAME: _____

Community Physician or Head Nurse to complete this section:

1. Does this student have any allergies? YES NO

If yes, please provide details/type(s) of reactions: _____

2. Has this student had any illness, operations, allergies, or injuries since beginning elementary school that require any medical attention? YES NO

If yes, please provide details: _____

3. Does this student have any disability or restriction(s) that prevents his/her full participation in school play or physical education activities?

YES NO

If yes, please give details: _____

4. Height: _____ Weight: _____

5. Does the student normally wear corrective lenses? YES NO

If yes,	Right	Left	Both
Vision with glasses	20/____	20/____	20/____
Vision without glasses	20/____	20/____	20/____

When was his/her last visit to the optometrist? _____

6. Are there any defects of:

- a) Sight _____ g) G.I. System _____
b) Hearing _____ h) G.U. System _____
c) Blood _____ i) Orthopedic _____
d) Nose _____ j) C. N. S. _____
e) Heart _____ k) Skin _____
f) Chest _____ l) Teeth _____

*Last dental visit: _____

7. Physical description:

Distinguishing marks, features, tattoos? _____

8. Does this student have any disability (including learning disabilities), or other conditions which should be observed periodically by the School Nurse?

YES NO

If yes, please explain: _____

9. During the last two years, has the student consulted, or been treated by, a psychiatrist, clinical psychologist, drug/alcohol counselor, or other mental health professional for any mental, emotional or psychological conditions, including eating disorders and substance abuse? YES NO

If yes, please give details: _____

10. Does this student have any prior suicide attempts: YES NO

If yes, please give details: _____

11. Please list any medications the student is currently taking: (name/dose/frequency/time)

12. Is student on any special diet? YES NO If yes, please explain:

13. Diabetic? _____ Smoke cigarettes? _____

14. Status Card / Health Card photocopy attached? YES NO

15. Are immunizations up to date?
(including Covid-19 vaccination) YES NO

Last TdP: _____

***Note:**

Before any student can enter the provincial systems, immunization records must be on file. This is not a choice, but is the LAW. A student can be refused entrance into a provincial school if there is no records on the school file.

Before any student will be placed in September, the counsellor must have received the immunization records. A photocopy of the Yellow Immunization Card is acceptable.

DATE	IMMUNIZATION	DATE	IMMUNIZATION

REMEMBER: NO IMMUNIZATION RECORD - NO PLACEMENT

Name of Medical Examiner: _____ Date: _____

Medical Examiner's Signature: _____

PLEASE ATTACH PHOTOCOPY OF HEALTH CARD AND STATUS CARD