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: <u>Student Medical Form</u>

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 ______________________
   - b) Hearing ______________________
   - c) Blood ______________________
   - d) Nose ______________________
   - e) Heart ______________________
   - f) Chest ______________________
   - g) G.I. System______________________
   - h) G.U. System ______________________
   - i) Orthopedic ______________________
   - j) C. N. S. ______________________
   - k) Skin ______________________
   - 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? 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