

**Medical Information**

TO BE COMPLETED BY PARENT/GUARDIAN	
Name of Student: _____	Birth Date: _____
School: _____	Grade: _____
Home Address: _____	
Telephone No. of Parent/Guardian (Home): _____	(Work): _____
Name of Emergency Contacts: _____	Phone: _____
_____	Phone: _____
Name of Physician: _____	Phone: _____

**Specific Potentially Life-Threatening Allergy(ies)**

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**The Nature of the Reaction**

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**Recommended Treatment in the Event of Accidental Exposure**

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Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

**Note: This form is to be filed in the School's Medical Emergency file and in the student's OSR File.**

**The information gathered on this form is pursuant to the *Education Act* and the *Municipal Freedom of Information and Protection of Privacy Act*. Information will be used to prepare assessment records; maintain records for all students. Users: Student Services Staff, Principal of Student, all teachers responsible for the Student's program and designated staff for clerical functions.**