****Form B: Student Health Information**

**Name of Student:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  | *Family Name* | | | | |  |  |  |  |  | *Official First and Second Names* | | | | | | | |  | |
|  | **□ Male** | **□ Female** | | | | | **Date of Birth:** | |  | | | / | |  |  |  | / | | |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  | Year | | |  |  |  | Month | |  |  | Day | | | | | | | |
|  | **Health Card #:** | |  | | | |  |  |  |  |  |  |  |  |  |  | **Province Issuing Health Card #:** | | | | | |  | | | |
|  | **Emergency Contact Name:** | | | | |  |  |  |  |  |  |  |  |  |  |  | **Relationship to Student:** | | | | |  | | | | |
|  | **Emergency Contact Phone Number:** | | | | | | |  | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Family Physician:** | | | | | |  |  |  |  |  |  | **# of Years: \_\_\_\_\_\_\_ Phone Number:** | | | | | | | | | | | | | |
|  | **Address:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | | | | |  | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Allergies:** | **□ Yes □ No** | | | | | If yes, please describe: | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | | | | | | | | |  |  |  | | | | | | | | | | |  | | |  |
|  | Using medication to treat allergies? **□** **Yes** **□** **No** | | | | | | | | | | | If yes, please describe: | | | | | | | | | | | | | | |
|  |  |  |  | | | |  | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Asthma:** |  | **□ Yes □ No** | | | | If yes, please describe: | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Using medication to treat asthma? **□** **Yes** **□** **No** | | | | | | | | | | | If yes, please describe: | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



**Immunizations:** *This record must include student’s most recent immunizations and may be obtained from your**Department of health, school, or family physician..*

I authorize and hereby consent to immunizations to be given should it be deemed necessary. **□ Yes** **□ No**

**An official copy of student’s immunization record must be attached to this form.**

*(Not required for Saskatchewan students)*

**Hospitalizations:**

****

**Mental Health:**

Has the student currently, or in the past, received counselling? **□ Yes □ No**

*Parents and/or student over 16 must provide a copy of the most recent assessment by counselor or doctor with regards to Mental Health. Written consent must be provided for LCBI to contact the counselor or doctor regarding the student’s assessment, treatment, and /or after-care program.*

Please provide information regarding any physical, emotional or mental condition that the student may have experienced. This information is vital to the student’s success at LCBI.



LCBI is a drug, alcohol, and tobacco-free campus. Please disclose any history of the following:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Alcohol Use:** | **□ Yes □ No** | **Drug Use:** | **□ Yes □ No** | | **Tobacco Use: □ Yes □ No** |  |
| If you answered yes to any of the above, please describe **history** of use: | | | |  |  |  |
|  | | | | |  |  |
| Has the student ever received treatment or counseling for addictions? | | | | |  |  |
| **□ No** | **□ Yes** | **□** Inpatient | **□** Outpatient | |  |  |

*Parents and/or student over 16 must provide a copy of the most recent assessment by counselor or doctor with regards to addictions. Written consent must be provided for LCBI to contact the counselor or doctor regarding the student’s assessment, treatment, and /or after-care program.*

**Medications:** Is your child taking any medication(s) other than for allergies or asthma? **□ Yes □ No**

**Current Medications:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Medication | Prescription or | | Dose & | Reason for Taking |
|  | Over the Counter | | Frequency |  |
|  |  |  |  |  |
|  | Pres. □ | OTC □ |  |  |
|  |  |  |  |  |
|  | Pres. □ | OTC □ |  |  |
|  |  |  |  |  |
|  | Pres. □ | OTC □ |  |  |
|  |  |  |  |  |
|  | Pres. □ | OTC □ |  |  |
|  |  |  |  |  |

**In case of Emergency if parent or legal guardian cannot be reached, please contact:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name:** | | | | **Relationship to Student:** | | |
|  |  |  |  |  |  |  |
| **Address:** | |  | |  |  |  |
| **Telephone:** | | |  | **Cell:** |  | |

*It is the policy of LCBI High School to contact parents/legal guardians in the event of serious or injury.*

**

**Authorization, Release, and Indemnity**

**To the best of my knowledge , the information I have provided is accurate and complete.**

I understand and acknowledge that the academic staff, dormitory staff and administrative staff of LCBI High School act in place and position of a parent or guardian of my child while my child is in attendance at LCBI High School. Recognizing this, I authorize each or any of them to provide my child with medical treatment they consider to be reasonable or necessary during the time period my child is in attendance at the school. I authorize screening for drugs and alcohol if deemed necessary. I will be informed of all results.

In consideration of their willingness to care for my child, I realize, remise and discharge, employees and agents from any and all liability, claims or causes of action which may arise, by virtue of the application, or non-application or medical treatment.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Dated at | |  |  | , in the Province of | | | | | | , | | |
| this |  |  | day of |  |  | | , 20 | | | . | |  |
|  |  | |  |  |  |  | |  |  |  |  |  |
|  | *Signature of Parent/Legal Guardian* | |  |  |  | *Signature of Parent/Legal Guardian* | | | |  |  |  |

***Failure to disclose or purposeful omission of information on this form will lead to a review of continuance.***