North Vancouver
School District
the natural place to learn®

SCHOOL SERVICES
Ph: 604-903-3489
Fax: 604-903-3445

Elementary Athletics Medical Form

Name of Student: _____ Grade: _____ ○ Male ○ Female

School: _____

BC Care Card No. _____ Birth Date (d-m-y): _____

Family Doctor: _____ Doctor Phone: _____

Name of Parent/Guardian: _____

Address: _____ Postal Code: _____

Phone: (Home): _____ (Work): _____ (Cell): _____

Please note any health condition (e.g., asthma, fainting, headaches, severe allergies/anaphylaxis, seizures, etc.), physical handicap, emotional difficulty, behaviour problem, or other factors that may limit full participation in this program.

Has the student had a previous injury that would require special first aid treatment should another injury occur?

The student has received the regular immunization program administered in BC for: Diphtheria; Pertussis & Tetanus (DPT); Tetanus and Diphtheria (TD); Polio; Measles, Mumps and Rubella (MMR).

○ Yes ○ No

If No, please explain:

Does the student wear Contact Lenses: ○ Yes ○ No

Alternate Emergency Contacts:

Name: _____ Phone: _____

Name: _____ Phone: _____

In case of emergency, I hereby give permission to the physician selected by the supervisor(s) to provide necessary treatment for my child.

_____ _____

Parent/Guardian Signature: Printed Name of Parent/Guardian:

Phone: _____

THIS INFORMATION WILL BE KEPT ON FILE

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