CHEAKAMUS CENTRE

nature is in session

STUDENT MEDICAL CONSENT

Name of child:_____ Male ❑ Female ❑

Birth date (m)_____(d)_____(y)_____. **BC Care Card Number**_____.

Child's School :_____. Dates Attending:_____to_____20___

Medical Information

1) I give permission for my child to be given Tylenol and/or Advil if needed: (parent's signature) X_____.
(Please supply if your child is likely to use this)

2) I give permission for my child to be given Gravol if needed: (parent's signature) X_____.
(Please supply if your child is likely to use this)

3) Date of most recent tetanus immunization:_____.

4) Chronic disability or illness:_____.

5) Known sensitivities/allergies or restrictions (please complete food allergies and special diets on reverse):_____.

_____.

6) Other medical conditions staff should be aware of (i.e. bed wetting, sleep walking, night terrors, migraines etc.)_____.

_____.

Prescribed Medications

I request and authorize my child's teacher, Cheakamus Centre staff or a qualified first aid person to administer the following medications prescribed by **Dr.**_____, **Phone #**_____as indicated below:

Name of medicine:_____. Name of medicine:_____.

What it is to be used for:_____. What it is to be used for:_____.

How it is to be given:_____. How it is to be given:_____.

Quantity to be given:_____. Quantity to be given:_____.

Times to be given:_____. Times to be given: :_____.

- **Medicines must be clearly labelled with the child's name, name of medication, what it is to be used for, quantity to be given, and times to be given. Additional information attached.**
- **Please contact Program Support Specialist with any concerns & additional information • 1-604-898-5422 ext.232 email: odsclinic@sd44.ca**

This section Must be Filled out Completely

Name of parent (guardian):_____. Name of parent (guardian): _____

Address:_____Postal Code:_____.

Home Phone #:_____. Cellphone #:_____. Work Phone#:_____.

If I cannot be contacted in the event of an emergency, please contact

Name Emergency Contact:_____. Home Phone #_____. Cellphone #:_____.

Cheakamus Centre staff (which includes the Board of Education of School District No. 44 (North Vancouver) and its employees, agents, contractors, representatives and volunteers) administer medication as directed above. To the best of their ability they: 1) administer the medications as prescribed; 2) treat reactions to prescribed medication if they occur; 3) store medication in a secure location and handle it as directed. In consideration of Cheakamus Centre staff taking on this role voluntarily, I forever discharge Cheakamus Centre staff and the Board of School Trustees of District # 44 from all actions and demands relating to administration of prescribed medications.

In case of emergency, I hereby give permission to the physician selected by Cheakamus Centre staff to provide treatment for my child.
Parent's signature: X_____. Date:_____.

Please TURN OVER, review and sign the back of this form

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FOOD ALLERGY AND SPECIAL DIET FORM

In order to satisfy your child's dietary requirements, please fill out Allergy Section entirely and the relevant sections that follow as completely as possible. You may add additional information as needed. Please note that this is for allergies and special diets only, not for dislikes.

Name of child:_____ Male ❑ Female ❑

School Attending:_____. Dates Attending: to

Food Allergies

My Child has NO food Allergies ..... ❑ Correct **> go to next section**

My Child is Allergic to_____/_____/_____/_____.

Trace amounts okay?	Yes ❑	No ❑
In baking okay?.....	Yes ❑	No ❑
Life Threatening?.....	Yes ❑	No ❑
Epi Pen Required?.....	Yes ❑	No ❑
Okay if label states that product "May contain trace amounts" of product?	Yes ❑	No ❑
Okay if label states "Made in a factory that uses" product?.....	Yes ❑	No ❑
Medications sent in case of contact (also fi ll out reverse section "Medications")	Yes ❑	No ❑

Lactose Intolerance

My Child has **NO** Lactose Intolerance ..... ❑ Correct **> go to next section**

Small amounts okay?.....	Yes ❑	No ❑
Dairy in baking okay?.....	Yes ❑	No ❑
Cheese okay?.....	Yes ❑	No ❑
Ice Cream okay?.....	Yes ❑	No ❑

*Please note we have milk alternatives (rice, soy)

Other Special Diets

My Child has NO other Special Diet restrictions ..... ❑ Correct **> please sign below**

Lacto ovo vegetarian (no meat or fish, but eggs and dairy are okay)	Yes ❑	No ❑
Lacto vegetarian (no meat, fish or eggs, but dairy is okay)	Yes ❑	No ❑
Vegan (no meat, fish, eggs, dairy or animal product: honey, gelatin etc).....	Yes ❑	No ❑
Pescatarian (no meat but fish, eggs and dairy are okay)	Yes ❑	No ❑
Gluten free (no wheat products or ingredients with gluten).....	Yes ❑	No ❑
Celiac disease	Yes ❑	No ❑
Other (please handwrite below).....	see below	

Additional food you will send to supplement diet:_____.

Other dietary restrictions and additional comments:_____.

Parent's Signature:_____. Date:_____