Hamilton Hebrew Academy
האקדמיה העברית בהמילטון

ב"ה

Medical Information Form

Student: ____Date of Birth: ______________

Grade/Class: ____

Parent/Guardian: _____________________________________ Telephone: (H) __________________ (B) _____________

Ontario Health Number: ______________________Family Doctor: ______________________ Telephone: _______________

Medical Conditions

Please indicate any significant medical conditions, physical limitations, or any other concerns that might affect your child's full participation in school activities.

- ☐ Asthma
- ☐ Fainting Spells
- ☐ History of head injuries
- ☐ Chronic Nosebleed
- ☐ Feet or Leg problems
- ☐ Chronic Migraine
- ☐ Seizures
- ☐ Diabetes
- ☐ Hemophilia/Bleeding disorders
- ☐ Digestive upsets
- ☐ Heart problems
- ☐ Recent illness or operation
- ☐ Chronic Urinary infections
- ☐ Chronic Ear, Nose, Throat infections
- ☐ Other ____________________ ____________________

Give details of usual treatment for each of the above conditions indicated: ____
____

Please explain if your child/ward has any medical condition that requires any modification of his/her program.
____
____

Allergies/Asthma

Please list all known confirmed allergies to the following:

(a) Foods: ____

If foods are life-threatening, please explain the symptoms and the treatment: ____________________________________
____

(b) Medications: ____

(c) Other (e.g., bee or wasp stings, environmental allergies): ____

Has your child suffered any serious allergic or asthmatic reaction? Y / N

If so, please provide details, including the type and severity of reaction: ______________________________________

Is allergy considered: Mild____ Moderate____ Serious____ Life-Threatening____

Hamilton Hebrew Academy
האקדמיה העברית בהמילטון

ב"ה

Has a doctor prescribed an Epi-Pen for your child Yes____ No____

Has a doctor prescribed an inhaler for asthma? Yes____ No___

Has a doctor prescribed an inhaler for any other reason? Yes____ No____

Dietary Restrictions

Please list any foods your child/ward should not eat for medical or dietary reasons: ______________________________________

____

Medication

Does your child/ward take prescribed medication on a regular basis? Please specify: ______________________________________

What prescribed medication(s) should your child/ward have with him/her during school trips? ______________________________

General

(1) Does your child wear or carry medical alert identification (e.g., bracelet)? Yes____ No____

If yes, please specify what is written on it: ____

(2) Does your child have any other relevant medical condition that will require modification of the program? Yes____ No____

If yes, please explain: ____

(3) Does your child have any special fears or conditions (e.g., anxiety, bed-wetting, nightmares), the knowledge of which will allow

the teacher to make the student feel more relaxed? Yes____ No____ If yes, please explain: _________________________

Should it become necessary for my child to have medical care, I hereby give the teacher/staff member permission to use her/his best judgment in obtaining the best of such service for my child. I also understand that in the event of such illness or accident, I will be notified as soon as possible.

Name of Parent/Guardian: ____*(Please print)*

Signature of Parent/Guardian: ____Date: _______________

Name of Parent/Guardian: ____*(Please print)*

Signature of Parent/Guardian: ____Date: _______________

60 Dow Avenue· Hamilton, Ontario · L8S 1W4

Tel (905) 528-0330 · Fax (905) 528-0544 · school@hamiltonhebrewacademy.ca · www.hamiltonhebrewacademy.ca

Hamilton Hebrew Academy is a beneficiary agency of The Hamilton Jewish Federation