



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 #: _____

Concussions: Yes No If yes, how many and dates: _____

Allergies: Yes No If yes, please describe: _____

Using medication to treat allergies? Yes No If yes, please describe: _____

Dietary Restrictions: Yes No If yes, please describe: _____

Asthma: Yes No If yes, please describe: _____

Using medication to treat asthma? Yes No If yes, please describe: _____

Hospitalizations: Yes No If yes, please describe _____

Please list past injuries: _____

Medications: Is your child taking any medication(s) other than for allergies or asthma? Yes No
Please note if Dorm staff are required to administer

Current Medications:

Name of Medication	Prescription or Over the Counter	Dose & Frequency	Reason for Taking How long?
	Pres. <input type="checkbox"/> OTC <input type="checkbox"/>		
	Pres. <input type="checkbox"/> OTC <input type="checkbox"/>		
	Pres. <input type="checkbox"/> OTC <input type="checkbox"/>		
	Pres. <input type="checkbox"/> OTC <input type="checkbox"/>		



Authorization, Release, and Indemnity

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 staff officers, employees, and agents 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

Media Release Question

I give consent to allow photos/videos of my child to be used for marketing and media purposes on our social media accounts through posts, videos and stories. Photos may also be used on our website to promote attendance for future events.

Yes No

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