STUDENT MEDICAL INFORMATION FORM

Student Name: _____ **Grade:** ____ **Birthday:** _____

Student Address: _____

Parent's Names: _____ **Phone Numbers:** _____

Doctor: _____

Doctor's Phone Number: _____

Care Card: _____

Allergies: _____

Medication: _____

Medical Conditions: _____

Life Threatening? Yes ☐ No ☐ (Please Circle)

EMERGENCY CONTACT:

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Relationship to Student: _____

_____ _____

Parent (Guardian) Signature **Date**

****Please inform the school of any changes to the above****

All information collected on this form will be used solely by WCAS in accordance with the Personal Information Protection Act
*Any misleading or inaccurate information may render this application null and void, with enrolments resulting from this application being terminated.

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