



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

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.