

# Sample Curricular Medical Information and Acknowledgement of Elements of Risk Form

*PLEASE NOTE: FREEDOM OF INFORMATION- The information provided on this form is collected pursuant to the Board's education responsibilities as set out in the Education Act and its regulations. This information is protected under the Freedom of Information and Protection of Privacy Act and will be utilized only for the purposes related to the Board's Policy on Risk Management. Any questions with respect to this information should be directed to your school principal.*

**Parents/guardians are requested to complete this medical information form and acknowledgement of Elements of Risk Notice and return to their child/ward's teacher.**

Name of Student:

Grade:

Name of Teacher:

(Where your child's/ward's condition is confidential or requires further explanation you are requested to contact your child's/ward's teacher.)

Date of last complete medical examination:

Date of last tetanus immunization:

Is your child allergic to any drugs, food or medication/other?

Yes

No

If yes, provide details:

## Medic Alert Information

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Does your child/ward wear a medical alert bracelet?

Yes

No

Does your child/ward wear a neck chain?

Yes

No

Does your child/ward carry a medical alert card?

Yes

No

If yes, please specify what is written on it:

## Oral and Visual Appliance

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Does your child/ward wear eyeglasses?

Yes

No

Does your child/ward wear contact lenses?

Yes

No

Does your child/ward wear orthodontic appliance?

- Yes
- No

Does your child/ward have dental restorations (that is, crowns, bridges)?

- Yes
- No

## Medical Conditions

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Indicate if your child/ward has been diagnosed as having any of the following medical conditions and provide relevant details:

- Allergies
- Anaphylaxis
- Asthma
- Deafness
- Epilepsy
- Heart disorders
- Type I Diabetes
- Type II Diabetes

Other:

Relevant details:

Please provide relevant details and accommodations (for example, Plan of Care) to be made if your child cannot fully participate in physical activities:

## Medications

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Does your child/ward take any prescription drugs?

- Yes
- No

If yes, provide details:

What medication(s) should be accessible during the physical activity?

Who should administer the medication?

## Physical Ailments

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Indicate any physical ailments that apply and provide relevant details:

- Arthritis or rheumatism
- Chronic nosebleeds
- Dizziness

- Fainting
- Headaches
- Hernia
- Orthopaedic conditions
- Spinal conditions
- Swollen, hyper-mobile or painful joints
- Trick or lock knee
- Head or back conditions or injuries (in the past two years)

Relevant details:

## Concussion

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Has your child/ward previously been diagnosed with a concussion?

- Yes
- No

How many times?

When was the last diagnosis? [month/day/year]

What medical advice was given by a medical doctor/nurse practitioner about participating in future physical activity?

If your child/ward is presently diagnosed with a concussion by a medical doctor/nurse practitioner, that was sustained outside of school physical activity, a [Medical Concussion Assessment Form](#) must be completed before the student returns to physical education classes and daily physical activity (DPA). Request the form from the school administrator.

## Other Conditions

Please indicate any other condition that will limit participation or that the teacher should be aware of:

## Elements of Risk Notice

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I acknowledge and have read the Elements of Risk notice in the [Curricular Parent/Guardian Letter](#).

Parent/Guardian Signature:

Date: