BRITISH COLUMBIA CHRISTIAN ACADEMY
MEDICAL INFORMATION (Confidential)

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STUDENT'S NAME:_____ BIRTHDATE: _____
(Please Print Clearly) year/month/day

PARENT/GUARDIAN: _____

Address: _____

_____Phone:_____

Previous address (in last 5 years): _____

EMERGENCY CONTACTS (Please list 2 people other than parents):

1._____ Phone:_____

2._____ Phone:_____

Personal Health Number: (MSP) ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (obtainable after 3 months in BC)

BCCA Private Medical Insurance Policy #: _____ Coverage from _____to _____
(Please note: all students MUST have adequate Medical insurance at all times. Private Medical Insurance is required until MSP coverage is obtained)

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Please **fill in dates** of all past immunizations, including those given by doctor:

DPTPH (Penta)(Diphtheria/ Acellular Pertussis/Tetanus/ Inactivated Polio/ Haemophilus Influenza Type B):
1. _____
2. _____
3. _____
4. _____

HEPATITIS B:
1. _____
2. _____
3. _____

MMR (Mumps/Measles/Rubella):
1. _____
2. _____

KINDERGARTEN BOOSTER (DPTP) (Diphtheria/Acellular Pertussis/ Tetanus/Inactivated Polio:
Date: _____

VARICELLA (CHICKENPOX) for children who have not already had Chickenpox, the disease:
1. _____

You may have to contact your physician for a record if you do not have a copy of immunizations he/she has given your child. Please keep the health unit informed of any additional immunizations done after providing this record. The school's public health nurse would be pleased to discuss the student's immunization or any other health concern.

1. Is the student currently taking any medication on a regular basis? Yes ☐ No ☐

Please provide the name(s) of the medication: _____

(Please turn over)

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2. Will the need to take this medication while at school? Yes ☐ No ☐

3. Does the student have a history of previous medical concerns or surgery? Yes ☐ No ☐

Please provide details: _____

_____

_____

4a. Does the student have any known allergies? Yes ☐ No ☐
If yes, please name allergies: _____

4b Symptoms that student has experienced during an allergic reaction are: _____

_____

_____

5. Has the student ever suffered an allergic reaction that has caused him/her to experience breathing difficulties, dizziness,
fainting, or shock? Yes ☐ No ☐

Please provide details: _____

_____

_____

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6. Has the student ever had need of oral (tablet or liquid) or injectable medication for an allergic reaction? Yes ☐ No ☐

If "Yes" please contact the school for an additional form.

Please rest assured that if the student is in need of assistance for a medical emergency, the school will attempt to inform you immediately. The student will, however, be promptly cared for whether or not we are able to contact you.

In the case of a medical emergency the school will attempt to contact you, or the guardian, to pick up your child or for direction as to what action to take. If you or the guardian is unavailable; the emergency contacts will be notified. If the school is unsuccessful in reaching a contact person we will take action as deemed necessary and keep trying to make contact with the parents/ guardians until successful.

Please use this space if there is anything else you want us to know about the student:

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