STUDENT MEDICAL INFORMATION

Date:	
Student name:	Agency:

EMERGENCY CONTACTS (please provide 2 contacts)

Surname:	First name:	
Relationship to student:	Address:	
City:	Country:	Postal code:
Phone: (incl. country & city code)	Email:	

Surname:	First name:	
Relationship to student:	Address:	
City:	Country:	Postal code:
Phone (incl. country & city code) :	Email:	

MEDICAL HISTORY

1. Previous surgery and/or serious illness (with dates):
2. Fractures sustained (with dates):
3. Drug allergies:
4. Food allergies:
5. Pet allergies:
   (Please note that most Canadians have pets. Any pet allergies may require a medical note.)
6. Regular medication taken (over-the-counter or prescription):
7. Does the student wear glasses? ☐ Yes ☐ No Contact lenses? ☐ Yes ☐ No
8. Does the student require any routine injections? ☐ Yes ☐ No If yes, please describe:

STUDENT MEDICAL INFORMATION

River East Transcona School Division
International Education Program

9. Is there a family history of any illness that we should be aware of? ☐ Yes ☐ No If yes, please describe:

10. Does the student have (or have they *had*) any of the following? If yes, please describe in comments.

- ☐ Appendicitis
- ☐ Asthma
- ☐ Chicken pox
- ☐ Cough (persistent, recurring)
- ☐ Diabetes
- ☐ Drug/alcohol dependency
- ☐ Eating disorder—anorexia, bulimia or other:
- ☐ German measles
- ☐ Headache (recurring)
- ☐ Hepatitis
- ☐ Malaria
- ☐ Measles
- ☐ Menstrual cycle problems
- ☐ Mumps
- ☐ Poliomyelitis
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Rhinitis
- ☐ Scarlet fever
- ☐ Seizure disorder
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vertigo, dizziness
- ☐ Whooping cough
- ☐ Other:

Comments:

11. Please list all vaccinations administered and dates:

12. Have you ever consulted with or been treated by specialists for mental health issues? ☐ Yes ☐ No

If yes, what year? And please describe:

13. Do you have a perceived or documented learning or physical disability? ☐ Yes ☐ No

If yes, please describe:

14. Do you have a perceived or documented social integration or behavioural concern? ☐ Yes ☐ No

If yes, please describe:

PLEASE NOTE: WE MAY REQUIRE ADDITIONAL DOCUMENTATION FROM A MEDICAL PROFESSIONAL.

STUDENT MEDICAL INFORMATION

PERMISSION FOR MEDICAL CARE & RELEASE HISTORY OF MEDICAL & PSYCHOTIC CONDITIONS

Date:	
Student name:	Agency:

I, as the Applicant's parent/ legal guardian, authorize the River East Transcona School Division—International Education Program to act for me in any emergency, accident or illness during the time that ______________________________
Name of student
is registered in the International Education Program.

I confirm that (a) the applicant student is not affected or does not have a history of medical, psychiatric or emotional difficulties; and (b) the applicant student does not have a condition that would impact the student's ability to be successful as an international student in the River East Transcona School Division—International Education Program. (c) My signature confirms that all conditions have been disclosed.

____
Parent or legal guardian's full name (please print)

______________________________ ______________________________
Signature Date

Please return this form to the International Education Program before your arrival.