

# Willowglen School

Westoak Trails Montessori Campus

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## MEDICAL INFORMATION

Health History of \_\_\_\_\_

Gender: \_\_\_\_\_

Date of Birth: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Health Card Number \_\_\_\_\_

Allergies \_\_\_\_\_

Are these allergies severe enough that he/she is considered anaphylactic? Yes / No \_\_\_\_\_

Is it necessary to keep medication at school? If yes, please state medication. \_\_\_\_\_

Has your child ever had any serious illnesses? \_\_\_\_\_

Explain. \_\_\_\_\_

Has your child's eyes ever been tested? Yes/No \_\_\_\_\_ Results \_\_\_\_\_

Has your child's hearing ever been tested? Yes/No \_\_\_\_\_ Results \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Emergency contact if parents cannot be reached:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone : work \_\_\_\_\_ home \_\_\_\_\_

### Parents' Consent Form:

In case of emergency resulting from an accident of illness where prompt medical attention is deemed necessary, and the parents cannot be immediately contacted, I hereby give my permission to take the above mentioned child to the nearest medical facility and to proceed with medical treatment. I understand that any medical expenses incurred for such treatment are my responsibility.

Dated \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_