WESTERN QUÉBEC

Greater Gatineau Elementary School
2019-2020

# EMERGENCY/HEALTH INFORMATION

**Information contained on this health form will be transmitted, if needed, to the nurse and to school staff that may need to intervene in case an emergency should arise with your child. In case of accident or illness, school staff will administer first aid, will ensure the student receives the care needed and will notify the parents as soon as possible. Ambulance transportation fees in case of emergency will be charged to the parents.**

## Student Information

Printed on: 2019-01-30

| Last Name | First Name (usual) | Middle Name |
|---|---|---|
| | | |

| Date of Birth (Y/M/D) | Gender ☐ M ☐ F | Grade Level | Health Insurance Number - Expiry |
|---|---|---|---|
| | | | |

## Parent/Guardian Information

| Adult Responsible: ☐ Father ☐ Mother ☐ Guardian | Guardian's Last Name & First Name |
|---|---|
| Mother's Last Name & First Name | Father's Last Name & First Name |

## Address

Type of Address: ☐ Father and mother ☐ Mother only ☐ Father only ☐ Legal guardian

| Street Address | Apt. Number | P.O. Box |
|---|---|---|
| City | | Postal Code |
| Phone # (at home) | Phone # (cell-Father) | Phone # (cell-Mother) |
| Phone # (at work-Father) | Phone Number (at work-Mother) | |

## Additional address

Type of Address: ☐ Mother only ☐ Father only ☐ Legal guardian

| Street Address | Apt. Number | P.O. Box |
|---|---|---|
| City | | Postal Code |
| Phone # (at home) | Phone # (cell-Father) | Phone # (cell-Mother) |
| Phone # (at work-Father) | Phone Number (at work-Mother) | |

## Emergency Contact Information

If the parents cannot be reached, please list below who to contact in case of an emergency, early school closing, or bus problems - either a neighbour, family member or friend.

**Name:** _____ **Day Time Phone Number:** _____

**Name:** _____ **Day Time Phone Number:** _____

## Health Information (Please indicate medical restrictions - Use the reverse side if necessary)

**Allergies:** Yes ☐ No ☐ **Please specify:** _____

**Does he/she have an Epipen?** Yes ☐ No ☐ **Location of Epipen:** On him/her ☐ At Office ☐ Daycare ☐

**Diabetes:** Yes ☐ No ☐ **Epilepsy:** Yes ☐ No ☐

**Asthma:** Yes ☐ No ☐ **If yes:** Mild ☐ Moderate ☐ Severe ☐ **Inhaler:** Yes ☐ No ☐ At School ☐ Requires Assistance ☐

**Does he/she take any medication?** Yes ☐ No ☐ **Please specify:** _____

**Physical Disabilities:** _____

**Is there any contra-indication for your child to participate in physical education class?** Yes ☐ No ☐
If yes, a recent medical certificate is required for exemption or limitation in physical activity.

**Other Conditions:** _____

**Please provide the emergency medication as of the first day of school and ensure that it remains valid for the whole school year (take note of expiry date).**

_____ _____

**Parent/Guardian Signature** **Date**

# For students with severe allergy and auto-injector only

## Anaphylaxis emergency plan

Name of student: _____ Birth date: _____ Group / Level : _____

**This person suffers from anaphylaxis; an allergy could be fatal for him/her.**

Attach your child's recent picture

*Check appropriate box:*

| | | | |
|---|---|---|---|
| Peanuts | ☐ | Insects bites | ☐ |
| Nuts | ☐ | Latex | ☐ |
| Eggs | ☐ | Other, specify : | ☐ _____ |
| Milk | ☐ | | |

Expiry date _____ / _____
Month / Year

***For elementary schools only :***

Epinephrine auto-injector ☐ 0,15mg (weight from 15 to 30kg)
☐ 0,30mg (weight ≥ 30kg)

Auto-injector accessible : ☐ At the waist ☐ in a place designated by the school

**The undersigned parent or guardian authorizes any adult to administer epinephrine to the above-named person in the event of an anaphylactic reaction, as described above.**

**An anaphylactic reaction can manifest itself with ANY ONE of the following symptoms**

- **Skin**: Hives, swelling, itchiness, redness, warmth.
- **Respiratory system**: Wheezy breathing, shortness of breath, choking, cough, hoarse voice, tightness of the chest, nasal congestion or hay-fever –like symptoms (runny nose or itchy nose, watery eyes, sneezing) difficulty swallowing.
- **Gastro-intestinal system** (stomach): nausea, cramps or pain, vomiting, diarrhea.
- **Cardiovascular System** (heart): pale or bluish skin, weak pulse, loss of consciousness, dizziness, light-headedness, state of shock.
- **Other symptoms**: anxiety, feelings of distress, headache.

**Act quickly. The first signs of a reaction can be mild, but symptoms can get worse very quickly**

1. **Administer the epinephrine auto-injector** at the first sign of a reaction occurring in conjunction with a known or suspected allergen contact.
2. **Call 911.** Tell them someone is having an anaphylactic reaction. Ask them to send an ambulance immediately.
3. **Administer a second dose of epinephrine** 5 to 15 minutes after the first injection IF the reaction persist or worsen.
4. **Go to the nearest hospital,** even if the symptoms are mild or have stopped.
5. **Call contact person.**

| Name | Relationship | Home phone | Work phone | Cell phone |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Please advise the school as soon as possible of any change of telephone number or address.**

**It is the parent's obligation to ensure that the auto-injector is valid throughout the school year.**

_____ _____

Parents or Guardian signature Date