**Medical Information – Relay Race «Je bouge… j’apprends!»**

**Confidential**

 **STUDENT INFORMATION**

Name : ................................................................................................................................

Address: ...........................................................................................................................................

............................................................................................................................................................

Date of birth: ....................................................................... Age:……….

Medicare number: .............................................................................................................................

Name of father: ....................................................................................................................................

Tél : home :………………..… Work : …………..……… Cell.: ……..……………

Name of mother : ................................................................................................................................

Tél : Home :………………..… Work : …………..……… Cell.: ……..……………

**EMERGENCY**

In case of emergency and the parent is not available, who should we contact?

Name : ............................................................. Relation : Friend, neighbor, grand-parent :…………

Tél. : ...............................................................

Family Doctor: ........................................................ Téléphone :.............................................

**HEALTH INFORMATION**

Health problems: (Please circle all that applies)

Allergy – What? ……………………………………….

Epipen : Allerject : ………………………………….

Asthma. Frequency of attacks?.......................................……… Inhalers: yes/no

Diabetes. Medication: yes/no Name: .....................................................................

Epilepsy. Frequency of attacks: ............... Medication.................................................

Heart problems: yes/no

Other : ……………………...........………………………………………………………..

Medication? Name : ..................................................................................................................................................................

Vaccination against tetanus? Yes/no Date of last shot: ..............................

**PARENT AUTORISATION**

I give permission to the supervising adults to provide the necessary care in case of emergency, to provide first aid and to transport my child to the nearest place for care. If ambulance transportation is needed, this will be the parent’s cost.

Date : ................................................ Signature of parent: ...........................................................