Athol Murray College of Notre Dame

Student Health Information
2014 - 2015

(to be completed by parent/legal guardian – please print clearly)

In our role ***in loco parentis,*** *we assume the responsibility as parent while your child is at Notre Dame. It is necessary for us to have the most complete and up to date information possible in order to ensure your child's well-being and safety while promoting their success here at the College. Please answer this form accurately.*

Failure to disclose or purposeful omission of information on this form may be reason for expulsion.

Name: _____ ***DOB:*** _____/_____/_____
Last Name Legal First and Second Names Year Month Day

Family Physician: _____ ***Number of Years:*** _____

Address: _____

_____ ***Phone Number:*** ( ) _____

Hospital/Medical Insurance: ***Provincial Health Card Number:*** _____ ***Province:*** _____

Allergies: Yes _____ No _____ If yes, please describe_____

_____

Using medication to treat allergies? Yes _____ No _____ If yes, please describe _____

_____

Asthma: Yes _____ No _____ If yes, please describe_____

_____

Using medication to treat asthma? Yes _____ No _____ If yes, please describe _____

_____

Immunizations: This record must include their most recent immunizations and may be obtained from your Department of Health, school or family physician. I authorize and hereby consent to immunization to be given should it be deemed necessary. Yes _____ No _____

Dental/Orthodontic History: _____

_____

Hospitalizations: Yes _____ No _____ If yes, please describe _____

_____

_____

Counseling:
Has the student currently, or in the past, received counseling? Yes _____ No _____

If you answered yes, you are required to provide the most recent evaluation. Written consent must be provided allowing the College's Nurse to contact the counselor or medical professional regarding the student's diagnosis, treatment and on-going care.

Please provide information regarding any physical, emotional or mental condition that the student may have experienced. This information is vital for the student's success at Notre Dame.

_____

_____

Has the student ever received any treatment or counseling for addictions? Yes _____ No_____ Inpatient _____ Outpatient _____

If yes, you MUST provide the most recent evaluation from their treatment center/addictions counselor. Written consent must be provided allowing the College's Nurse to contact the counselor or doctor regarding the student's assessment, treatment and/or after-care program.

Medications: Is your child taking any medication(s): Yes _____ No _____

Current Medications:

NAME	PRESCRIPTION	OVER THE COUNTER	DOSE & FREQUENCY	REASON FOR TAKING

Note: Athol Murray College of Notre Dame is an alcohol, drug and tobacco free campus. Please disclose any history of the following:

Alcohol Use: Yes _____ No _____ ***Drug Use:*** Yes _____ No _____ ***Tobacco Use:*** Yes _____ No _____

If yes to any of the above, please describe _____

In Case of Emergency if parent or legal guardian cannot be reached, please contact:

_____ _____
Name Relationship to the Student

_____
City Prov/State Country

( ) _____ ( ) _____
Home Telephone Number Cell Number

It is the policy of the college to contact parents/legal guardians at the earliest opportunity in the event of serious illness or injury.

AUTHORIZATION, RELEASE, AND INDEMNITY

To the best of my knowledge, the information I have provided is accurate and complete.

I understand and acknowledge that the staff officers, employees and agents of Athol Murray College of Notre Dame act in place and position of a parent or guardian of my child while my child is in attendance at the College. Recognizing this, I authorize each or any of them to provide my child with medical treatment that they consider to be reasonable or necessary during the time period my child is in attendance at the school. I authorize screening for drugs and alcohol if deemed necessary. I will be informed of all results.

In consideration of their willingness to care for my child, I release, remise and discharge, employees and agents from any and all liability, claims or causes of action which may arise, by virtue of the application, or non-application of medical treatment.

_____ _____
Signature of Parent/Legal Guardian Name of Parent/Legal Guardian ***(please print)***

_____ _____
Signature of Parent/Legal Guardian Name of Parent/Legal Guardian ***(please print)***

_____
Date