Oceanview Christian Academy

MEDICAL INFORMATION

STUDENT INFORMATION

Child's full name: _____

Date of Birth (dd/mm/yyyy) _____

Health Card # _____

Expiry Date: _____

Local Physician: _____

Physician's Phone #: _____

Does applicant have any mental, emotional, physical limitations, or learning disabilities that may affect his/her activities or progress, or for some reason should be known by his/her teachers?:

ALLERGIES

Please specify if your child has any allergies:

MEDICATIONS

NOTE: If medication is required on a regular basis, or at a specified time, medication must be brought to the school office, labeled with child's name and dosage requirements, and a medical permission form must be completed.

Specify if your child requires regular medication to be administered at school:

☐ By signing this form I understand that Oceanview Christian Academy is not responsible for any injury or harm that may occur as a result of this medication. Oceanview Christian Academy reserves the right to revoke this privilege if it is being abused (constant use of pain medication, etc.).

PERMISSION TO RECEIVE MEDICATION

In order to receive pain medication, students must check with their Home Room teacher before coming to the school office for such medication.

My child will be permitted to be given the following pain medication(s) during school hours if necessary, understanding that this does not mean they are allowed to abuse this privilege. (Please check all allowable ones)

☐ Tylenol (Acetaminophen)
☐ Advil (Ibuprophen)
☐ Gravol Kids
☐ My child is not permitted to receive any medications

EMERGENCY MEDICAL TREATMENT

I hereby authorize Oceanview Christian Academy to call an emergency ambulance in case of accident or acute illness, and to arrange for necessary emergency medical aid and surgical care in the case that I, or the designated guardian, am not immediately available. Any qualified physician, called by OCA, may treat and do whatever is necessary for the health and well-being of my child.

It is understood that a conscientious effort must be made to notify me before such action will be taken. I also agree to accept responsibility for the cost of above medical services.

Parental Signature(s):

_____ _____
Father Date

_____ _____
Mother Date

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