

2025-2026 MEDICAL FORM

ATTACH ADDITIONAL SHEETS AS REQUIRED

STUDENT'S NAME: _____ **GRADE:** _____
PLEASE COMPLETE AND SIGN.

1. DOES THE STUDENT HAVE ANY HISTORY OF ALLERGIC REACTION? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN: _____

2. DOES THE STUDENT CARRY AN EPI-PEN? ☐ YES ☐ NO
IF YES, PLEASE COMPLETE THE INDIVIDUAL ANAPHYLAXIS EMERGENCY PLAN FORM

3. DOES THE STUDENT HAVE ANY MEDICAL ILLNESS OR INJURY OR SUFFER FROM ANY OF THE FOLLOWING:

DIABETES:	<input type="checkbox"/> YES <input type="checkbox"/> NO	VISION DIFFICULTY:	<input type="checkbox"/> YES <input type="checkbox"/> NO
ASTHMA:	<input type="checkbox"/> YES <input type="checkbox"/> NO	EPILEPSY/SEIZURES:	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART DISEASE:	<input type="checkbox"/> YES <input type="checkbox"/> NO	SPEECH DIFFICULTY:	<input type="checkbox"/> YES <input type="checkbox"/> NO
DEAFNESS:	<input type="checkbox"/> YES <input type="checkbox"/> NO		
MENTAL HEALTH ISSUES:	<input type="checkbox"/> YES <input type="checkbox"/> NO		
EMOTIONAL/BEHAVIOURAL ISSUES:	<input type="checkbox"/> YES <input type="checkbox"/> NO		

OTHER, PLEASE EXPLAIN:

4. DOES THE STUDENT REQUIRE PRESCRIPTION MEDICATION ADMINISTERED AT SCHOOL?
☐ YES ☐ NO IF YES, PLEASE COMPLETE THE FOLLOWING:

I _____ (PARENT/GUARDIAN NAME) GIVE MY CONSENT TO GREENHILL ISLAMIC SCHOOL TO ADMINISTER THE FOLLOWING MEDICATION:

_____ (MEDICINE NAME)

PRESCRIBED AND APPROVED BY DR. _____ IN CASES OF EMERGENCY TO MY CHILD.

DOCTOR'S OFFICE CONTACT NUMBER: _____

IN CASE OF EMERGENCY, PERMISSION IS HEREBY GIVEN TO GREENHILL ISLAMIC SCHOOL TO:

- ADMINISTER FIRST AID,
- CONTACT 911 FOR MEDICAL ATTENTION IF REQUIRED,
- RELEASE THE ABOVE INFORMATION TO A MEDICAL PRACTITIONER IF REQUIRED,
- CONTACT PARENTS IN ALL CASES

PARENT/GUARDIAN NAME: _____ SIGNATURE: _____

DATE (YYYY/MM/DD): _____

Phone: (905) 328-0339