



**Emergency Contact** (custodial parents will always be contacted first)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Home Address: \_\_\_\_\_

Street	City	Prov	Postal Code
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Home Phone: \_\_\_\_\_ Unlisted

Business Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Unlisted

Cellular Phone: \_\_\_\_\_ Unlisted

Email address: \_\_\_\_\_

Can this contact person pick up the student?  Yes  No

**Emergency Contact** (custodial parents will always be contacted first)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Home Address: \_\_\_\_\_

Street	City	Prov	Postal Code
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Home Phone: \_\_\_\_\_ Unlisted

Business Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Unlisted

Cellular Phone: \_\_\_\_\_ Unlisted

Email address: \_\_\_\_\_

Can this contact person pick up the student?  Yes  No

Before/After School Care: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**Medical Information**

CareCard No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**Doctor's contact information required if student has a life-threatening condition.**

**Life Threatening Health Condition:**  Yes  No

If the student has a life-threatening health condition, **please arrange to meet with the school principal prior to the student attending school.**

The life-threatening health conditions that apply to this student are:

Anaphylactic or Severe Allergies to food or insect stings Allergen(s): \_\_\_\_\_

Asthma that has resulted in hospitalization in the past year \_\_\_\_\_

Blood Clotting Disorder (e.g. haemophilia) \_\_\_\_\_

Diabetes \_\_\_\_\_

Epilepsy with a history of Tonic-Clonic (Grand Mal) seizures in the past two years \_\_\_\_\_

Serious Heart Condition (e.g. heart murmur, heart repair) \_\_\_\_\_

Other Health Conditions which may require emergency care - please specify: \_\_\_\_\_

**Non-life-threatening health conditions:**

If the student has a non-life-threatening health condition which may affect his/her ability to function at school (e.g., vision impairment, hearing impairment, activity limitation, mental health disorder), please indicate here: \_\_\_\_\_

**Medication Administration:**

I request that the student receive assistance with, or be supervised during, medication administration in an emergency.

The student requires medications to be administered during school hours for one month or longer. **Please contact school staff to discuss.**

Name of Medication(s): \_\_\_\_\_

**Parental Authority for Regular School Journeys**

I give my permission for this student to participate in school field trips for the school year. I understand that I will be notified of all field trips to be taken.

I prefer to give separate written permission for each field trip that this student will attend.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Parental Authority for Accessing Electronic Communication Systems**

In accordance with Regulation 5131.9 *Student Acceptable Use of Electronic Communications Systems in Schools*,

I grant permission

I do not grant permission.

I understand that a copy of the regulation is available in the school office.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**I certify that the information I have provided on this form is correct:**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

The school has a Parent Advisory Council (PAC) that represents the parents and engages in activities in support of the school. The school PAC is a member of the Victoria Confederation of Parent Advisory Councils (VCPAC). The school will normally make the parent/guardian name, phone number and mailing address as well as the student's name and grade available to the PAC and to VCPAC for contact purposes.

**I give permission for the release of my name, home phone number, mailing address, and the student's name and grade to the school PAC  and to VCPAC .** (Check each box to indicate that permission is given for each and then provide a signature below.)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date