ECOLE SALISH SECONDARY

Medical Information

(PLEASE PRINT CLEARLY)

I Name____ Date ____________________

Student Number ___________________________________ Male__________Female ____________

Present Address ____

Phone Number ______________ Age_____________ Birthday ___________________
Day Month Year

Email

____

II Care Card # _______________________________________

Name of Family Doctor______________________________Telephone ____________________________

III Mother's Name ____

Telephone ______________________________ Email _____________________________

Father's Name ____

Telephone ______________________________ Email _____________________________

IV Please describe any medical or physical conditions that the school should be made aware ofin regards to your son/daughter (i.e. Epilepsy, Diabetes, etc.)

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Student Signature: ____

Parent/Guardian _______________________________

Signature: