

ADDENDUM D

Emergency Medical Treatment Form

	SCHOOL: _____
STUDENT'S NAME: _____	GRADE LEVEL: _____
STUDENT'S QUÉBEC HEALTH INSURANCE NO. : _____	EXPIRY DATE: _____
MEDICAL ALERTS, ALLERGIES, ETC. (SPECIFY TYPE): _____	
IF MEDICATION HAS BEEN PRESCRIBED, PLEASE SPECIFY TYPE: _____	
<ul style="list-style-type: none"> • <i>If the student is using prescribed medication for asthma and/or allergies, he/she must carry this medication on his/her person at all times. Failure to do so will result in the student being disallowed from participating in this event.</i> • <i>You are responsible for submitting a revised form if there any changes in the medical information you are providing.</i> 	
NAME OF FAMILY PHYSICIAN (IF AVAILABLE): _____	
<h3>EMERGENCY MEDICAL TREATMENT</h3> <p>The undersigned hereby agrees that, in the event that I or my spouse or parent/tutor/guardian cannot be contacted within a reasonable period of time, the person in charge be appointed to authorize the admission to hospital, if deemed necessary by a medical doctor, and emergency medical treatment recommended by a medical doctor be given to the above named student while participating in this activity, trip and related events.</p>	
NAME OF ADULT STUDENT, PARENT, TUTOR OR LEGAL GUARDIAN(s) (PLEASE PRINT): _____	
HOME ADDRESS: _____	
HOME TELEPHONE #: _____	ALTERNATE TELEPHONE #: _____ Neighbour or Relative
BUSINESS TELEPHONE #: _____	_____
Father	Mother
CELL #: _____	_____
Father	Mother
GUARDIAN: Home # _____	Cell #: _____
_____	_____
Signature and Relationship	Date

This form must be completed for all types of trips or activities off school premises