



# Our Lady Of Victory School

249 Arnold Ave.  
Winnipeg, Manitoba  
R3L 0W5

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## New Student Medical Form

**PLEASE PRINT**

Name \_\_\_\_\_ Applying for Grade \_\_\_\_\_

Manitoba Health Registration # (6digit) \_\_\_\_\_ Personal Health ID # (9digit) \_\_\_\_\_

Physician's Name \_\_\_\_\_ Doctor's Office Phone No. \_\_\_\_\_

Additional Health Coverage (Blue Cross, etc.) \_\_\_\_\_

Please indicate any Health Care needs:

My child is not experiencing any health problems at this time.

Epi-Pen       Bronchial Inhaler       Asthma       Anaphylaxis

Allergies (identify) \_\_\_\_\_

Disabilities \_\_\_\_\_

Regular Medication \_\_\_\_\_

Elaborate on Health Care needs, if necessary: \_\_\_\_\_

**Emergency Procedures:**

If your child should become ill or injured during the school day, the school will notify the parents. If we are unable to reach the parents we will call your designated contact(s) below. In the event that we are unable to reach neither the parents or emergency contact(s), it is the school's policy that a staff member take the child to the Children's Hospital or the nearest hospital. While we hope that we never have to use your authorization to do so, we would appreciate it if you would grant us this authority by completing the following. In the event that an ambulance is deemed necessary, the parent/guardian shall be billed for this service.

Please check (T):

I agree with the above procedure.

I do not agree with the above procedure and request that the school:

**Unless contact information is kept up-to-date and this form is completed and signed, the school will not be held responsible for following the above procedures.**

**Emergency Contact 1:**

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_ Cell Phone No. \_\_\_\_\_

**Emergency Contact 2:**

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_ Cell Phone No. \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent(s) / Guardian(s)

## PERMISSION TO ADMINISTER MEDICATION

If your child has a chronic condition that requires medication on a daily basis, or on a periodic basis and you wish to leave medication at the school so your child will have access to it as needed, please complete the form below.

Student Name \_\_\_\_\_

Student's Address \_\_\_\_\_

Birthdate \_\_\_\_\_ Medication \_\_\_\_\_

When to be given and how much: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I hereby request and authorize that my child be given medication as prescribed by our doctor. Such medication is to be given by the school's designated personnel. This authorization is considered to be valid until June 30<sup>th</sup> next following this date, unless withdrawn by the doctor or parent(s)/guardian(s).

Parent/Guardian Name \_\_\_\_\_  
*(Please Print)*

\_\_\_\_\_ *(Relationship to Student)*

\_\_\_\_\_ *Date*

\_\_\_\_\_ *Signature of Parent(s) / Guardian(s)*

## AUTHORIZATION BY DOCTOR TO ADMINISTER MEDICATION

I hereby give permission for this child to be given the following medication at school. Such medication is to be given by the school's designated personnel. This authorization is considered to be valid until June 30<sup>th</sup> next following this date, unless withdrawn by parent/guardian or doctor.

**PLEASE SUPPLY NAME OF DRUG, THE DOSAGE TO BE ADMINISTERED, THE TIME OF DAY IT IS TO BE GIVEN, POSSIBLE SIDE EFFECTS AND REASON FOR MEDICATION TO BE GIVEN.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Doctor \_\_\_\_\_  
*(Please Print)*

\_\_\_\_\_ *Date*

\_\_\_\_\_ *Signature of Doctor*