School year 2025-2026

HEALTH FORM – HIGH SCHOOL

Please complete and return to Ms.Pilon at jpilon@wqsb.qc.ca

Name : _____ First Name: _____

Sex : M ☐ F ☐ Birth date : _____

Teacher's name _____ Grade level : _____

Medicare number : _____ Expiration date : _____

Address : _____ Apartment : _____

City : _____ Postal Code : _____

Father's name : _____

☎ Home : _____

☎ Work : _____ Ext. _____

Cellular or pager # : _____

E-mail : _____

Mother's name : _____

☎ Home : _____

☎ Work : _____ Ext: _____

Cellular or pager # : _____

E-mail : _____

In the event a parent is unreachable please provide alternate contacts :

Name	Relationship	Home Phone	Work Phone	Cell Phone

Please advise the school as soon as possible of any change of telephone number or address.

In order to ensure the security of your child, the school must be informed of any **health problem that might necessitate an emergency intervention at school** (severe allergy, severe asthma, diabetes and/or epilepsy) or any other health concern needing a particular care.

Does your child have :

Severe allergy with auto-injector? : Yes ☐ No ☐ **If yes, fill out emergency plan on reverse side ▶**

Asthma with pump(s)? : Yes ☐ No ☐

Diabetes : Yes ☐ No ☐

Epilepsy : Yes ☐ No ☐

Other : _____

Please ensure that your child has in his/her possession the auto-injector at all times and that it remains valid for the entire school year.

PHYSICAL EDUCATION

Is there any reason that your child cannot participate in physical education class? Yes ☐ No ☐

▶ If yes, a recent medical certificate is required for exemption or limitation in physical activity.

In case of accident or illness, school staff will administer first aid, will ensure the student receives the care needed and will notify parents as soon as possible. Ambulance transport fees in case of emergency will by charged to the parents.

Note: Information contained on this health form will be transmitted, if needed, to the CISSSO nurse and to school staff that may need to intervene in case an emergency should arise with your child.

_____ _____

Parent or guardian signature or student if 14 years of age or older Date

For students with severe allergy and auto-injector only

Anaphylaxis emergency plan

Name of student: _____ Birth date: _____ Group / Level : _____

This person suffers from anaphylaxis; an allergy could be fatal for him/her.

Check appropriate box:

Peanuts	☐	Insects bites	☐
Nuts	☐	Latex	☐
Eggs	☐	Other, specify :	☐ _____
Milk	☐		

Expiry date _____ / _____
Month / Year

For elementary schools only :

Epinephrine auto-injector ☐ 0,15mg (weight from 15 to 30kg)
☐ 0,30mg (weight ≥ 30kg)

Auto-injector accessible : ☐ At the waist ☐ In a place designated by the school

The undersigned parent or guardian authorizes any adult to administer epinephrine to the above-named person in the event of an anaphylactic reaction, as described above.

An anaphylactic reaction can manifest itself with ANY ONE of the following symptoms

- **Skin**: Hives, swelling, itchiness, redness, warmth.
- **Respiratory system**: Wheezy breathing, shortness of breath, choking, cough, hoarse voice, tightness of the chest, nasal congestion or hay-fever –like symptoms (runny nose or itchy nose, watery eyes, sneezing) difficulty swallowing.
- **Gastro-intestinal system** (stomach): nausea, cramps or pain, vomiting, diarrhea.
- **Cardiovascular System** (heart): pale or bluish skin, weak pulse, loss of consciousness, dizziness, light-headedness, state of shock.
- **Other symptoms**: anxiety, feelings of distress, headache.

Act quickly. The first signs of a reaction can be mild, but symptoms can get worse very quickly

1. **Administer the epinephrine auto-injector** at the first sign of a reaction occurring in conjunction with a known or suspected allergen contact.
2. **Call 911.** Tell them someone is having an anaphylactic reaction. Ask them to send an ambulance immediately.
3. **Administer a second dose of epinephrine** 5 to 15 minutes after the first injection **IF** the reaction persists or worsens.
4. **Go to the nearest hospital,** even if the symptoms are mild or have stopped.
5. **Call contact person.**

Name	Relationship	Home phone	Work phone	Cell phone

Please advise the school as soon as possible of any change of telephone number or address.

It is the parent's obligation to ensure that the auto-injector is valid throughout the school year.

_____ _____
Parent or Guardian signature Date