



Medical Information Form
Spain Trip 2010

Student name: _____

Date of birth: _____

Alberta Health Care No: _____

Passport No: _____

In an emergency, please contact:

| | |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Name: _____ Relationship to student: _____ Home #: _____ Cell #: _____ Work #: _____ | Name: _____ Relationship to student: _____ Home #: _____ Cell #: _____ Work #: _____ |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|

| |
|------------------------------------------------------------|
| Doctor's Name: _____ Phone number: _____ Address: _____ |
|------------------------------------------------------------|

Are Immunizations up to date: Yes _____ No _____

*Please note: No special immunizations are necessary for Spain.

Please indicate if your child has any of the following:

- | | |
|-----------------------------------------|------------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Dysmenorrhea | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Headaches | |

Other: _____

Allergies: Does your child carry an Epi Pen? Yes _____ No _____

Please indicate any allergies:

| Drug Allergies | Reaction (symptoms) and Treatment |
|----------------|-----------------------------------|
| | |
| | |
| | |
| | |
| | |

| Food Allergies | Reaction (symptoms) and Treatment |
|----------------|-----------------------------------|
| | |
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| | |

List any medication your child is taking any medication on a regular basis:

| Drug Name | Dosage | Scheduled Time |
|-----------|--------|----------------|
| | | |
| | | |
| | | |
| | | |

Over the Counter Medications that you give permission for your child to take, if needed:

- | | | |
|--------------------------------------------------|----------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> A535 Rub | <input type="checkbox"/> Cough Drops | <input type="checkbox"/> Metamucil |
| <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> Dristan Nasal Drops | <input type="checkbox"/> Ibuprofen (Motrin, Advil) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Exlax | <input type="checkbox"/> Ozonol or Polysporin |
| <input type="checkbox"/> Benadryl | <input type="checkbox"/> Gravol | <input type="checkbox"/> Pepto Bismol |
| <input type="checkbox"/> Canestin Cream | <input type="checkbox"/> Immodium | <input type="checkbox"/> Reactine |
| <input type="checkbox"/> Claritin | <input type="checkbox"/> Maxeran | <input type="checkbox"/> Vicks Rub |

Other: _____

Each student is responsible for carrying and taking their own medications.