collège saint-charles garnier

MEDICAL FORM

Customized programs
French as a foreign language

Your Picture
Write your name on back

To be returned as soon as possible to *Collège Saint-Charles-Garnier.*

Student Information		
Last name:	First name:	
Sex : ? M ? F	Age by July 1st 2003::	Birth date: / / D M Y
Adress:		
N°	Street	Apt.
City	Province	Postal code
Phone number: ( )	e-mail:	
Fax number: ( )		
Medicar number:	Social insurance number:	

Parent or tutor's information	
Father's name:	Mother's name:
Phone number: ( )	Phone number: ( )
Office number: ( )	Office number : ( )
Tutor's last name:	Tutor's first name:
Phone number : ( )	Office number : ( )

Other phone number in case of emergency		
Name:	Relationship:	Phone #: ( )
		Office #: ( )

Hospitalization and medical insurance	
Compulsory for international students. Non compulsory but recommended for Canadian students	
Insurance company:	
Insurance number:	**Assistance line:**

Health history

Previous illness (mark and give approximate dates)

	Measles		Ear trouble:		Bronchitis:
	Diphteria:		Dermatite:		Fracture:
	Whooping cough:		Scarlet fever:		Chickenpox:
	Tonsillitis:		Otitis:		Other:

Date of last vaccine received against tetanus?

Do you suffer from any of the following? (if yes, mark and specify)

	Asthma:		Digestion trouble:
	Vision trouble:		Frequent headaches:
	Heart trouble:		Breathing trouble:
	Diabetes:		Epilepsy convulsions:
	Skin desease		Physical handicap:
	Other:		

Comments:

Allergies

Do you suffer from any of the following.(if yes mark and specify)

Medicine, drugs:	Food:
Pets:	Other:

Actual physical health

Physical restrictions:

Anything special:

Name of your doctor:	Phone number: ( )

Special eating habits

Health:	Personal choice:
Religion:	Other:

Comments:

If you take medication, let us know all the pertinent information in case of an emergency. (name of medication, prescription, dosage, frequency, secondary effects, etc...)

Student's signature	Date:	Parent's signature:

Parent or tutor's authorization in case of hospitalization

In case of emergency, if I cannot be reached, I authorize the doctor recommended by the director of the program or its representative to hospitalize my child, to assure him of the best care and to prescribe if necessary some injections, anaesthesia or any other surgery.

Parent or tutor's signature:	Date: