

Emergency Health Record 2019-2020

WESTMOUNT HIGH SCHOOL

Additional information

(Fill only if your child has health problems that might require immediate intervention at school)

Has your child's state of health changed since last year: Yes No

Does your child suffer from:

SEVERE ALLERGY : To	➤ Food :	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	➤ Insect bites:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	➤ Other:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
or ASTHMA :		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If so, specify : _____			
Emergency medication :	Yes <input type="checkbox"/>	EpiPen or Twinject or Allerject :	Yes <input type="checkbox"/> No <input type="checkbox"/>
	No <input type="checkbox"/>	Other :	_____

DIABETES:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emergency medication :	Yes <input type="checkbox"/>	Specify : _____
	No <input type="checkbox"/>	
<input type="checkbox"/> Emergency care plan:	_____	
Other information in case of emergency	_____	

OTHERS : Does your child suffer from any other problems that may require immediate assistance at school ?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If so, specify : _____		
Medical recommendation in case of emergency :	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Specify :	_____	

I authorize the CSSS to keep this information on file, in a confidential manner and I authorize the CSSS nurse to transmit the information contained in this document to the school staff who may have to intervene in case of emergency.		
_____	Date :	____ / ____ / ____
Signature of parent/guardian	Year	Month Day

Changes in the state of health (during the school year):

