



Hugh Sutherland School
 R.R. #1 Carstairs, AB. T0M 0N0
 Phone: (403) 337-3326 Fax: (403) 337-3918
Principal: George Thomson
Vice Principals: John Goutsis



**CONSENT OF PARENT OR GUARDIAN AND
 "ACKNOWLEDGEMENT OF RISK" (OFF-SITE ACTIVITY/IES)**

We, the undersigned, as parent(s)/legal guardian(s) of _____
 consent to his/her participation in _____ to take place at _____ on the
 following date(s) _____.

Please list any physical handicaps: _____

Please list any medication your child is receiving: _____

| |
|--|
| Potential hazards may include but are not limited to the following: (if additional space required, add separate sheet) |
| Normal hazards associated with recreational activities which may include but not be limited to broken bones, sprains, tears, separations and possible death. |

This form must be signed by the parent/legal guardian before the school can permit the student to participate in the activity named hereon.

**ILLEGAL DRUGS AND ALCOHOL
 POLICY:** The possession and/or use of illegal drugs or alcohol on school property or at school-sponsored functions is prohibited and may lead to expulsion.

STUDENT MEDICAL RELEASE

Student's Full Name: _____ Age: _____ Date of Birth: _____

Address: _____

Mother's/Guardian's Name: _____ Phone: (home) _____
 (work) _____

Father's/Guardian's Name: _____ Phone: (home) _____
 (work) _____

Emergency Name: _____ Phone: (home) _____
 (Other than parent or guardian) (work) _____

Family Physician's Name: _____ Office Phone: _____

Alberta Health Care # (optional): _____ Health Plan (if any): _____
 Policy #: _____

Medical Conditions

Does your child have conditions that we should be aware of: (Y for yes, N for no or N/A for not applicable)

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ears | <input type="checkbox"/> Menstruation |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Nose | <input type="checkbox"/> A.D.D. |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Headache | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Intestines | <input type="checkbox"/> Seizures | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> Kidneys Urinary Tract | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Motion Sickness | |

If you answered YES to any of the above medical conditions, please fill in the appropriate spaces below. Include all pertinent information: **PRESCRIBED MEDICATIONS THAT YOUR CHILD WILL BE ON** should be listed under prevention or treatment.

Medical Information

| Medical Condition | FROM Month/Yr. | TO Month/Yr. | Frequency | Caused or Aggravated by | Usual Symptoms | Prevention | Treatment |
|-------------------|----------------|--------------|-----------|-------------------------|----------------|------------|-----------|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Allergies

Is your child allergic to:

- | | | | |
|-------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Ampicillin | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Erythromycin or Ilosone | <input type="checkbox"/> Foods |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Amoxil | <input type="checkbox"/> Other Medications | <input type="checkbox"/> Environmental Things |

If your child has allergies, please list them below and include symptoms and treatment

| Allergy | Symptoms | Treatment | Allergy | Symptoms | Treatment |
|---------|----------|-----------|---------|----------|-----------|
| | | | | | |
| | | | | | |

Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity, or from participating in any activities? If yes, please explain. Mention any recent surgery, illness, broken bones, injuries, physical conditions, allergies or other reason.

Do we have permission to administer to your child, if necessary:

- | | | |
|---|--|--|
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Robitussin Cough Syrup | <input type="checkbox"/> Imodium (antidiarrheal) |
| <input type="checkbox"/> Antibiotic Ointment (on cuts or scrapes) | <input type="checkbox"/> Polysporin Eye Ointment | <input type="checkbox"/> Chlortripolon (antihistamine) |
| | | <input type="checkbox"/> Polysporin Ear Drops |

Parents/Guardians' Authorization: This health information is correct to the best of my/our knowledge and the student herein described has my/our permission to engage in all activities unless other wise noted by me/us. I/we give permission to the physician or hospital, selected by the teacher or any adult in charge, to secure proper treatment and to order medications, injections, anesthesia or surgery for my/our child. Every effort will be made to contact the parent(s)/guardian(s). I/we also understand that any medical expenses not covered by Alberta Health Care will be paid for by me/us, the student's parent(s)/guardian(s).

Signature (Mother/Guardian): _____ Date: _____

Signature (Father/Guardian): _____ Date: _____

The personal information collected herein will be protected under the privacy provision of the *Freedom of Information and Protection of Privacy Act*. If you have questions about the use of the information, please contact the Principal or the FOIPP Coordinator of Chinook's Edge School Division at (403) 227-7070.