## Form 6. Student health information

**This Health Information Form is strictly confidential. For safety reasons, it is essential that the Activity Leader and the College have this information in case of a medical emergency.** If you are uncertain about the nature of the information being asked for, or if you are uncomfortable with certain questions, please discuss your concerns with the Activity Leader or the Person in Authority.

**Student**

**Last name**: Click here to enter text.

**First name**: Click here to enter text.

**Birth date** (d/m/y): Click here to enter a date.

**RAMQ number**: Click here to enter text. **Expiry date**: Click here to enter a date.

(Quebec health insurance number)

**Family doctor (if you have one)**

**Name**: Click here to enter text.

**Telephone**: Click here to enter text.

**Address**: Click here to enter text.

**Specialist** (cardiologist, neurologist, psychiatrist, psychologist, etc., if applicable) (click the blue plus symbol at right to insert additional specialists)

Name: Click here to enter text. Specialty: Click here to enter text.

Telephone: Click here to enter text.

Address: Click here to enter text.

**Health history**

It is essential to inform the activity coordinators of any relevant physical or psychological conditions so as to prevent any situation that could put your health at risk or interfere with the smooth running of the activity.

1. Do you suffer from recurring or chronic illnesses or conditions? Yes [ ]  No [ ]

If yes, please provide details. Click here to enter text.

Do you wear a Medical Alert tag? Yes [ ]  No [ ]

1. Have you been hospitalized, undergone any surgeries or sustained any serious injuries in the past two years that might affect your ability to participate in this activity?

Yes [ ]  No [ ]

If yes, please provide details. Click here to enter text.

1. Do you have any allergies? Yes [ ]  No [ ]

If yes, please complete the following table:

|  |  |  |
| --- | --- | --- |
| **Allergy to** | **Symptoms / type of reactions that you have experienced** | **Medication required** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

Will you bring an EpiPen® or equivalent: Yes [ ]  No [ ]

If yes, you must carry it with you at all times and the expiry date of the EpiPen® or equivalent should extend beyond the duration of the activity.

1. Do you have any food intolerances or special dietary restrictions? Yes [ ]  No [ ]

If yes, please provide details. Click here to enter text.

1. Do you have a physical disability or a serious limitation that could affect your mobility and your resistance (e.g., swelling in joints, recent injury, etc.) Yes [ ]  No [ ]

If yes, please provide details. Click here to enter text.

1. Do you have a psychological condition that might affect your ability to participate in this activity? Yes [ ]  No [ ]

If yes, please provide details. Click here to enter text.

1. Do you suffer from anxieties (e.g. fear of flying) or phobias (e.g. fear of spiders, snakes, etc.) that could affect you during the trip? Yes [ ]  No [ ]

If yes, please provide details. Click here to enter text.

1. Will you be taking any medications (prescriptions, homeopathic treatments and vitamins) on the trip? Yes [ ]  No [ ]

If yes, please complete the following table.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of medication, homeopathic treatments and vitamins (please include generic name)** | **Reason** | **Dosage** | **Do you experience any negative side effects from the use of this medication? If yes, please specify.** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Immunization information: [template to be completed after consultation with the nurse or travel clinic]**

Participants must consult a health care provider or visit a travel health clinic at least eight weeks before the date of departure in order to:

* review their immunization history;
* discuss any health concerns they may have related to the trip;
* assess their needs based on where they plan to travel and what they you plan to do.

**Required immunizations for this activity**

**Documentary proof of immunization must be submitted to the Activity Leader for all required immunizations.**

Click here to enter text.

**Recommended immunizations for this activity**

Click here to enter text.

**Participant’s statement**

I hereby certify that, to the best of my knowledge, the information on this form is complete in all details. I fully realize that any condition, mental or physical, that I am found to have, originating prior to my participation in this activity, and which is not described in full in this form or in an accompanying letter from a qualified health-care professional, might be cause for my return to Montreal, or treatment at my expense. Dawson College has neither responsibility nor liability arising from any such undisclosed condition.

All medication that I take regularly is at my expense, and has been detailed in this form.

**Participant**

Print name: Click here to enter text.

Student ID number: Click here to enter text.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click here to enter a date.

**Parent or legal guardian** (for participants under 18 years of age)

As the parent or legal guardian of the student whose signature appears above, I have read and understand the terms and conditions specified above, have given my child or ward permission to participate in the activity, and agree to be bound by the terms and conditions (including those that may subject me to personal financial liability) specified above.

Print name: Click here to enter text.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click here to enter a date.