

PLEASE PRINT

2009-2010

JOHN F. KENNEDY HIGH SCHOOL
STUDENT INFORMATION SHEET

SECONDARY LEVEL: _____

HOMEROOM: _____

FAMILY NAME: _____ FIRST NAME: _____

ADDRESS: _____
civic number street apt

TELEPHONE NUMBER: _____ CELL #: Mother's _____ Father's _____
city postal code

DATE OF BIRTH: _____ / _____ / _____ SEX: _____ Male _____ Female
year month day

PLACE OF BIRTH: STUDENT: _____ MOTHER: _____ FATHER: _____

MOTHER TONGUE: STUDENT: _____ MOTHER: _____ FATHER: _____

LANGUAGE SPOKEN AT HOME: STUDENT: _____ MOTHER: _____ FATHER: _____

FATHER'S NAME: _____ FIRST NAME: _____ LIVING/DECEASED: _____

MOTHER'S MAIDEN NAME: _____ FIRST NAME: _____ LIVING/DECEASED: _____

STUDENT LIVES WITH: _____ Both Parents _____ Mother Only _____ Father Only
_____ Guardian (Name : _____)

RELIGION: _____

SCHOOL ATTENDED LAST YEAR: _____

SIBLING (S) AT J.F.K.: _____ HOMEROOM: _____
_____ HOMEROOM: _____

FATHER'S EMPLOYER: _____ TELEPHONE: _____ EXTENTION: _____

MOTHER'S EMPLOYER: _____ TELEPHONE: _____ EXTENTION: _____

IN CASE OF EMERGENCY

Please indicate the names of two persons and their telephone numbers to contact in case parent(s) cannot be reached.

1. NAME: _____ TELEPHONE: _____
RELATION TO STUDENT: _____ LANGUAGE SPOKEN: _____
2. NAME: _____ TELEPHONE: _____
RELATION TO STUDENT: _____ LANGUAGE SPOKEN: _____

___ Check here if your present address and telephone number is different from the one on the June 2009 report card.

MEDICAL INFORMATION

MEDICARE NUMBER: _____ **EXPIRY:** _____

INFORMATION CONCERNING STUDENT'S HEALTH

Your child suffers from:

	YES	NO	Follow-up	Medication
Vision	_____	_____	_____	_____
Hearing	_____	_____	_____	_____
Language	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Neurologic Problem	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Heart Diseases	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____
Haemophilia	_____	_____	_____	_____
Handicap	_____	_____	> Specify: _____	
Allergies	_____	_____	> Specify: _____	
Other:	_____			

ATTENTION: IF YOUR CHILD SUFFERS FROM A LIFE-THREATENING ALLERGY, PLEASE NOTIFY THE SCHOOL IF THERE ARE ANY CHANGES IN YOUR CHILD'S HEALTH DURING THE YEAR, PLEASE INFORM THE SCHOOL IMMEDIATELY.

Does he/she wear prosthesis? Auditory: _____ Visual: (glasses) _____

Does your child take medication? If YES, please specify: _____

Has your child had an operation recently? If YES, please specify: _____

Is there any reason that your child cannot take part in any Physical Education class? ___ Yes ___ No

IF YES, A MEDICAL CERTIFICATE IS NEEDED FOR AN EXEMPTION FROM PHYSICAL EDUCATION COURSE.

AUTHORIZATION:

I authorize the nurse or/and any other member of the school staff to examine the information contained in this card.

In case of emergency or sudden illness, I authorize the school personnel to provide FIRST AID TREATMENT, necessary in case of an emergency when it is impossible to contact the parents. In case of an emergency, transportation costs if any will be at the parents' expense.

Parent's Signature: _____ Date: _____

JOHN F. KENNEDY High School

3030 Villeray
MONTREAL, QUEBEC
H2A 1E7

Health Record

TEL.: 514-374-1449

This record contains basic information on your child's state of health. We need this information in order to ensure the best possible learning environment and to enable a rapid and appropriate response in an emergency.

This record will be kept in the student's file. It is available to the staff of the CLSC (nurse, social worker), the teaching staff and the person in charge of first aid, if necessary. This record is valid for one year and must be completed at the beginning of each school year. It will be destroyed at the end of the year.

School Year: **2009-2010**

1. PERSONAL INFORMATION	
STUDENT (Family Name) _____	(First Name) _____
PRINCIPAL ADDRESS: _____ APT. _____	
CITY: _____	POSTAL CODE: _____
TELEPHONE: _____	DATE OF BIRTH: Y ____/M ____/D ____ SEX: F <input type="checkbox"/> , M <input type="checkbox"/>
MEDICARE CARD NUMBER: _____	Exp _____
BIRTH PLACE: _____	
DATE OF ARRIVAL IN QUEBEC (if student is born elsewhere): _____	
MOTHER TONGUE(S): _____	SPOKEN AT HOME _____
CURRENT LEVEL: _____	HOMEROOM: _____
NAME OF SCHOOL: JOHN F. KENNEDY HIGH SCHOOL	
SCHOOL ATTENDED LAST YEAR: _____	
CITY OR MUNICIPALITY: _____	
STUDENT LIVES WITH: <input type="checkbox"/> BOTH PARENTS <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> JOINT CUSTODY <input type="checkbox"/> GUARDIAN	
FATHER (Family and first name) _____	
ADDRESS: _____	TEL. WORK: _____
	TEL. HOME: _____
MOTHER (Family and first name): _____	
ADDRESS: _____	TEL. WORK: _____
	TEL. HOME: _____
GUARDIAN, if applicable (family and first name): _____	
RELATIONSHIP WITH STUDENT: _____	
ADDRESS: _____	TEL. WORK: _____
	TEL. HOME: _____
2. EMERGENCY (IF THE PARENTS CANNOT BE REACHED)	
FAMILY NAME: _____	FIRST NAME: _____
RELATIONSHIP WITH STUDENT: _____	TEL. WORK: _____
	TEL. HOME: _____
If necessary, I authorize the school staff to dispense first-aid care to my child. In an emergency, if it is impossible to reach the parents or guardians, I authorize the nurse and physician to ensure that my child receives the emergency care required. In an emergency, the cost of ambulance transport will be charged to the parents or guardians.	
SIGNATURE OF THE PARENTS'/GUARDIANS: _____ DATE: _____	

Identify your child's health problems with a check mark (✓). Specify the follow-up by a physician or specialist, the corrected problem(s) and any medication.

4. INFORMATION ON THE STUDENT'S HEALTH				
HEALTH PROBLEM(S) PHYSICAL OR PSYCHOSOCIAL	✓	FOLLOW-UP BY A PHYSICIAN OR SPECIALIST (indicate the name)	CORRECTED PROBLEM(S) (specify)	MEDICATION (specify)
Vision				
Hearing				
Language				
Dentition				
Asthma				
Diabetes				
Epilepsy				
Cardiac				
Emotional/Social Dimension				
OTHER(S) (neurological, digestive problem, physical, handicap)				

ALLERGIES: PEANUTS FEATHERS EGGS ANTIBIOTICS INSECT STING
OTHER(S)(specify) _____

TYPE OF REACTION: _____

USE OF THE EpiPen AUTO-INJECTOR MEDICATION: USE OF CORTISONE
OTHERS(S) (specify) _____

◆ NOTE ◆ : IF YOUR CHILD SUFFERS FROM AN ALLERGY THAT COULD PLACE HIS/HER LIFE IN DANGER, PLEASE INFORM THE SCHOOL ADMINISTRATION. FOR ANY CHANGE IN YOUR CHILD'S HEALTH DURING THE YEAR, CONTACT THE SCHOOL IMMEDIATELY.

ADDITIONAL RECOMMENDATIONS OR INFORMATION:

5. PHYSICAL EDUCATION

FOR ANY EXEMPTION FROM THE PHYSICAL EDUCATION COURSE RELATED TO A HEALTH PROBLEM, A MEDICAL CERTIFICATE IS REQUIRED.

6. AUTHORIZATION

I AUTHORIZE THE NURSE AND ANY OTHER MEMBER OF THE SCHOOL STAFF TO EXAMIN THE INFORMATION CONTAINED IN THIS CARD.

SIGNATURE OF THE PARENTS' OR GUARDIANS' _____ DATE: _____

7. INFORMATION FOR USE BY THE SCHOOL

--