



The future is in  
our hands.

# Turtle Mountain School Division

P.O. Box 280 Killarney, Manitoba R0K 1G0

Office: (204) 523-7531 Fax: (204) 523-7269

**ADMINISTRATION:**

**Larry Rainnie**

Superintendent

**Kathy Siatecki**

Secretary-Treasurer

**Tanya Edgar.**

Assistant Superintendent of  
Student Services

**Ken Rose**

Supervisor of Buildings & Maint.

**John Reimer**

Transportation Co-ordinator

## STUDENT MEDICAL TREATMENT AND RELEASE FORM

This form is to be signed and completed by the international student's parent or legal guardian and returned to the Turtle Mountain School Division Committee. Accurate and complete information is essential to ensure adequate supervision and protection while participating in the program. This information is confidential and will be available to the Turtle Mountain School Division staff administering the program, the homestay host and a physician, if necessary. The parent or legal guardian assumes full responsibility for the participant's health, recognizing that this program may at times be of a strenuous nature both physically and mentally and that the activities will in no way aggravate any present conditions.

Student's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Town/City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Country: \_\_\_\_\_ Postal/Zip Code: \_\_\_\_\_

Home Telephone No: \_\_\_\_\_ Home Fax No: \_\_\_\_\_

**KOREAN INFORMATION:**

Doctor's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Korean Insurance Policy #: \_\_\_\_\_ Identification: \_\_\_\_\_

Hospital Insurance #: \_\_\_\_\_ Health Card#: \_\_\_\_\_

**CANADIAN INFORMATION:**

International Student Health Policy #: \_\_\_\_\_ Identification #: \_\_\_\_\_

**PERSONAL HEALTH RECORD**

Check/circle any of the following conditions which the student is subject to:

Asthma	Epilepsy	Kidney trouble	Nightmares
Sleepwalking	Tonsillitis	Ear trouble	Convulsions
Bed wetting	Eye trouble	Motion sickness	Fainting
Bronchitis	Frequent colds	Skin conditions (contagious)	Skin conditions (non-contagious)
Menstrual cycle problems	Sinus trouble	Boils	Rheumatism
Hysteria	Headaches (migraines)	Anorexia/Bulimia	Constipation
Other:			

Please give details of usual treatment should indicate conditions occur:

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Circle any of the following allergies, which the student is subject to:

Animals      Drugs      Foods      Pollen      Plants      Insect Stings      Other

Specify: \_\_\_\_\_

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Signs/Symptoms: \_\_\_\_\_

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Treatment: \_\_\_\_\_

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Please circle any of the following illness which the student has had:

Appendicitis	Typhoid Fever	Pleurisy	Scarlet Fever
Chicken Pox	Jaundice	Pneumonia	Tuberculosis
German Measles	Mononucleosis	Poliomyelitis	Mumps
Heart Disease	Rheumatic Fever	Whooping Cough	Measles
Diabetes	Hepatitis	Ulcers	Malaria

Is the student currently taking prescription/non-prescription medication? \_\_\_\_\_

Name of Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_

Condition for which drug was prescribed: \_\_\_\_\_

Doctor who prescribed medication: \_\_\_\_\_

Vaccination: \_\_\_\_\_ Date: \_\_\_\_\_ Reaction: \_\_\_\_\_

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Are all immunizations up to date? \_\_\_\_\_

Recent injuries/fractures and operations (please detail and provide dates):

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Please list any physical limitations that Turtle Mountain School Division staff and the homestay host should be aware of:

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Precautions that have been advised by a doctor:

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Other conditions which staff and homestay host should be made aware of (specify details and medication necessary):

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Has the student had a recent eye examine? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide date of examination: \_\_\_\_\_

Has the student had a dental exam within the last six months? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide date of examination: \_\_\_\_\_

Please indicate if the student is a vegetarian: \_\_\_\_\_ Yes \_\_\_\_\_ No

Please indicate any special dietary requirements: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FIELD TRIP

I give permission for \_\_\_\_\_ to participate in field trips arranged by the school.

Parent(s)/Guardian(s) Signature: \_\_\_\_\_

Parent(s)/Guardian(s) Signature: \_\_\_\_\_

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

## MEDICAL

Please list any medical conditions that Turtle Mountain School Division staff should be aware of:

\_\_\_\_\_

Please list any physical limitations that Turtle Mountain School Division staff should be aware of:

\_\_\_\_\_

I/we as parent(s)/guardian(s) of the undersigned student do hereby authorize Turtle Mountain School Division staff and the Custodian to consent to any X-ray examinations, anaesthetic, medical or surgical diagnosis or treatment or hospital care which is deemed advisable by, and is rendered under any licensed physician or surgeon, whether such treatment or diagnosis is rendered at the office of said physician or surgeon or at a hospital.

It is understood that this authorization is not given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the Turtle Mountain School Division and/or Canadian Custodian to give specific consent to any and all such diagnoses, treatment, or hospital care which the aforesaid physician or surgeon in the exercise of his/her best judgment may deem advisable.

We, \_\_\_\_\_ parents/guardians agree to accept financial responsibility in excess of the benefits allowed by the International Student Health Plan

\_\_\_\_\_  
Name of Parent/Guardian (father)      Parent/Guardian's Signature      Date

\_\_\_\_\_  
Name of Parent/Guardian (mother)      Parent/Guardian's Signature      Date

\_\_\_\_\_  
Name of Custodian      Custodian's Signature      Date

\* We, \_\_\_\_\_ parents are aware that dental work, eye examinations, glasses, prescriptions, are not insured by the International Student Medical Plan. We are responsible for these costs.