



**STUDENT MEDICAL /HEALTH INFORMATION**

Family Physician Name: ..... Tel.: .....

Physician Address:.....

Health Card Number (OHIP) .....

- Medical Conditions/ Allergies (Please List)** 1. ....
2. ....
3. ....

Is the student taking any medication on a regular basis? Yes  No

If yes, please indicate: .....

Is the student fit to participate in sports and physical exercise? Yes  No

If no, please explain: .....

Please indicate any other medical conditions we should be aware of (if any)

.....  
.....

**PARENTAL CONSENT FOR EMERGENCIES**

In the event of any injury requiring medical attention, I hereby grant permission to SILC to share any information listed within this form with the supervising teacher, staff or medical personnel in order to attend to my child during school hours. I understand the every effort will be made to contact me, however, if the injury warrants emergency medical attention and I am unreachable, I grant permission to SILC school for necessary medical treatment to be given, including permission to transport my child/children to nearest medical facility.

Parent / Guardian Signature

Date: .....

**E-MAIL AUTHORIZATION**

Please Add My E-mail Address To The School's Mailing List To Receive Important School Announcements And Updates.

Contact:

Tariq Ghorl	416.953.3984	Zeelaf Fatima	647.877.7221
Kamran Siddiqui	416.464.1630	Saeed Zafar	416.875.7734