Landmark East School
708 Main Street
Wolfville, Nova Scotia
B4P 1G4 CANADA

Tel: (902) 542-2237
Fax: (902) 542-4147
www.landmarkeast.org

PARENT AUTHORIZATION

2019-2020

Student's Full Name: _____

Weekly Allowance (BOARDING STUDENTS ONLY)

We authorize our child to receive a weekly allowance of $_____ *(max $25.00)* to be included in our child's personal expenses paid by us.

Use of Photograph or Likeness

We authorize Landmark East School and its employees, agents and personnel who are acting on behalf of the school to use our child's photograph or other likeness for purposes related to the educational mission of the school, including publicity, marketing and promotion of the school and its various programs. We understand that our child's photograph or likeness may be copied and distributed by means of various media, including video presentations, television, news bulletins, mail outs, billboards or signs, brochures, placement on school website or newspapers. We understand that, although Landmark East School will endeavour to use our child's likeness in accordance with standards of good judgment, the school cannot warranty or guarantee that any further dissemination of our child's photograph or likeness will be subject to school supervision or control. Accordingly, we release the school from any and all liability related to dissemination of our child's photograph or likeness.

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

_____ _____

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CREDIT CARD AUTHORIZATION

For Student Personal Expenses

Student's Full Name: _____

I hereby authorize Landmark East School to debit my credit card on a monthly basis for my child's personal expenses. These expenses may include but are not limited to:

- Weekly allowance (boarding students)
- Weekend activities and/or other school activities (e.g. field trips, winter carnival, etc.)
- Transportation fees (students using Landmark East's transportation service)
- Art and Production Technology supplies
- School photos

Furthermore, I authorize Landmark East School to use my credit card to pay:

- **Wood's Limousine** for my child's transportation costs (www.woodslimo.com)
- **Cochrane's Pharmasave** for my child's medication, prescriptions, toiletries, etc.
- **Annapolis Valley Health Authority** for any out-of-province medical fees
- Other medical and/or health services (e.g. dentist, counsellor, eye glasses, etc.)

Credit Card Information

Card Type: ❑ VISA ❑ MasterCard

Credit Card Number: _____

Card Expiry Date: _____

Card Security Code: _____

Cardholder Name: _____

Cardholder Signature: _____

Cardholder Email: _____

Is this the same credit card used the previous school year? ❑ Yes ❑ No ❑ New Student

_____ _____

SIGNATURE DATE

NOTE: Please contact Janet Cooper at (902) 542-2237 Ext 227 or *jcooper@landmarkeast.org* to update your credit card information when necessary.

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MEDICAL INFORMATION

(To be completed by parents)

Student's Full Name: _____ Sex: **Male** **Female**

Date of Birth (YYYY/MM/DD): _____|_____|_____

Provincial Medical Number: _____ Expiry Date: _____

Parents/Legal Guardians: _____

Full Mailing Address: _____

Home Tel: _____ Mother's Cell: _____ Father's Cell: _____

Emergency Contact Person: _____ Address: _____

Address: _____ Home Tel: _____ Cell: _____

Family Doctor: _____ Tel: _____

Full Mailing Address: _____

Health and Medication:

Does student have allergies? **Yes** **No** If yes, give details _____

Is student on a special diet? **Yes** **No** If yes, give details _____

Does student have hyperactivity? **Yes** **No** If yes, does student take stimulant medication? **Yes** **No**

Has female student menstruated? **Yes** **No** If no, has she been told about it? **Yes** **No**

Is menstrual history normal? **Yes** **No** If no, give details _____

Does student take medication? **Yes** **No** If yes, give name of medication(s) and also complete Medication form with all details:

_____

PARENT AUTHORIZATION

We (I) hereby give permission for teachers and staff of Landmark East School to administer first aid or any other assistance they consider to be in the best interest of our (my) child. In the event that we (I) cannot be reached in an emergency, we (I) hereby give permission to the physician selected by the school to hospitalize, secure treatment for and to order injection, anaesthesia, or surgery for our (my) child as named above. We (I) hereby authorize the Landmark East School physician to examine our (my) child and prescribe medications, as he/she deems necessary. Furthermore, we (I) hereby assign Landmark East School the authority to arrange provision for any emergency or routine dental care the school deems necessary to ensure adequate dental health of our (my) child as named above and we (I) agree to assume responsibility for any costs involved.

_____ _____

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MEDICATION

(To be completed by parents)

Student's Full Name: _____ **Sex**: ❑ Male ❑ Female

Date of Birth (YYYY/MM/DD): _____|_____|_____

Does student take medication? **Yes** **No**

If yes, list **ALL** medications in the chart below indicating the times of administration and the dosage. Also, please indicate whether medication is to be given 5 days per week or 7 days per week.

Name of Medication	Reason	Times	Dosage	5 or 7 Days per Week

Additional Instructions (e.g. emergency procedures) _____

_____

_____

Should medication be sent home with student on weekends and/or holidays? **Yes** **No**

Please give details. _____

_____

IMPORTANT: Parents must email Glen Currie at gcurrie@landmarkeast.org if there is any change in their child's medication (discontinue, change in dosage, new medication, etc.).

_____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

_____ _____
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IMMUNIZATION RECORD

Student's Full Name: _____ **Sex**: ❑ Male ❑ Female

Date of Birth (YYYY/MM/DD): _____|_____|_____

VACCINE	DATE					
	First	**Second**	**Third**	**Fourth**	**Fifth**	**Sixth**
DTaP-IPV-Hib						
DTaP-IPV						
Diptheria						
Tetanus						
Pertussis						
Poliomyelitis						
Hib						
MMR						
Varicella						
Measles						
Rubella						
Hepatitis B						
Meningococcal C						
Other						
Other						

*DTaP-IPV-Hib = Diptheria, Tetanus, Acellular Pertussis, Polio, Haemophilus Influenza B

Notes: _____

_____

_____

_____

I have completed the above immunization record.

_____ _____
Signature Date

Printed Name: _____ Telephone: _____

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MEDICAL REPORT

(To be completed by a licensed physician)

Student's Full Name: _____ **Sex**: ❑ Male ❑ Female

Date of Birth (YYYY/MM/DD): _____|_____|_____

Health History

Does child have a chronic or recurring illness? ❑ No ❑ Yes - _____

Does child have allergies? ❑ No ❑ Yes - _____

Is child on a special diet? ❑ No ❑ Yes - _____

Does child have any hearing difficulties? ❑ No ❑ Yes If yes, is a hearing screening evaluation recommended? ❑ No ❑ Yes

Does child have a history of epilepsy or other neurological problems? ❑ No ❑ Yes - _____

_____

Are you aware of mental health contact for behavioral, emotional or attention problems? ❑ No ❑ Yes

If yes, give details and name of contact person. _____

_____

What is the psychological climate in the child's home? _____

_____

Examination (This examination is for determining fitness to engage in strenuous activities.)

Height: _____ Weight: _____

Legend: (**N**) Normal

____ Blood Pressure	____ Haemoglobin Test	____ Hernia	____ Eyes	____ Extremities
____ Urinalysis	____ Ears	____ Skin	____ Posture	____ Teeth
____ Nose	____ Throat	____ Abdomen	____ Heart	____ Lungs

Specific activities to be encouraged: _____

Specific activities to be discouraged: _____

I have examined the above-named student and have completed this Medical Report. It is my opinion that this child is physically able to engage in school activities, except as noted above.

_____ _____

Signature of Examining Physician Date

Printed Name: _____ Telephone: _____

Address: _____

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VISION REPORT

(To be completed by an optometrist or ophthalmologist)

Student's Full Name: _____ **Sex**: ❑ Male ❑ Female

Date of Birth (YYYY/MM/DD): _____|_____|_____

Visual Examination

	Right Eye	Left Eye	Both Eyes
Visual acuity for distance:	_____	_____	_____
Visual acuity for near:	_____	_____	_____

Eye muscle imbalance tests (Heterophoria or Strabismus – tendency or actual – cross eyes):

Distance: _____ Near: _____

Stereopsis Test (for depth perception): _____

Suppression Test (Are both eyes functioning adequately?): _____

Fusional amplitude (Can child control his/her eye coordination?): Distance: _____ Near: _____

Colour Perception Test (Ishihara's Test) – Is there any existing defect? ❑ Yes ❑ No

Are glasses required? ❑ Yes ❑ No

If yes: ❑ At all times ❑ School work

Note: Attach eye glass prescription to this vision report.

I have completed this vision report for the above-named student.

_____ _____
Signature of Optometrist/Ophthalmologist Date

Printed Name: _____ Telephone: _____

Address: _____

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DENTAL REPORT

For Boarding Students Only

(To be completed by a dentist)

Student's Full Name: _____ **Sex**: ❑ Male ❑ Female

Date of Birth (YYYY/MM/DD): _____|_____|_____

Dental Examination

The above-named student has had a dental examination, cleaning and fluoride treatment within the past six (6) months and has had all necessary dental work completed.

Comments:

_____

_____

_____

_____

_____

_____ _____

Signature of Dentist Date

Printed Name: _____ Telephone: _____

Address: _____