Fleming College
Student Health & Emergency Information Form

To support your health, safety, and well-being during camps, field trips, and other off-campus learning activities, students are encouraged to complete this form and return it in a sealed envelope with their full name clearly printed on the front before the activity begins.

Providing this information is voluntary. Any information you choose to share will be used only to support your health and safety while participating in the activity. You are encouraged to include any information that may assist college staff in responding appropriately in the event of an emergency or in supporting your participation.

Consent and Authorization

I, _____ (Student Name), understand that the information provided on this form is being collected to support my health and safety while participating in a college-approved camp, field trip, or other off-campus activity.

I authorize faculty members, technicians, academic administrators, and other designated staff directly responsible for supervising the activity to access this information only when necessary to support my health, safety, or well-being. In the event of a medical emergency, relevant information may also be shared with healthcare professionals, emergency responders, or medical authorities to ensure appropriate care.

I understand that my personal health information will be treated as confidential and will only be accessed by authorized individuals who require the information to fulfill their responsibilities. The information will be securely maintained during the activity and securely destroyed following the completion of the event in accordance with college procedures.

If you have questions about how your information is collected, used, or protected, please contact your Program Coordinator, Academic Chair, Dean, or another authorized college representative.

Student Signature: _____

Date (DD/MM/YYYY): _____ / _____ / _____

Student Number: _____

Personal Information

Full Name: _____

Permanent Address: _____

City/Town: _____

Province/State: _____

Country: _____

Postal/ZIP Code: _____

Health Card Number: _____

Emergency Contact Information

Emergency Contact Name: _____

Relationship to Student: _____

Primary Phone Number: _____

Secondary Phone Number (Optional): _____

Family Physician/Health Care Provider: _____

Physician Phone Number: _____

Health Information

The information below will help us respond appropriately in an emergency and support your participation in the activity.

Allergies

Do you have any medication allergies?

☐ Yes ☐ No

If yes, please provide details:

Food Allergies or Sensitivities

☐ Yes ☐ No

If yes, please list the allergy/sensitivity, severity, and date of most recent reaction:

Environmental Allergies

Examples: pollen, animal dander, insect stings, latex.

☐ Yes ☐ No

If yes, please provide details:

Insect Sting Allergy

Do you have an allergy to bee or wasp stings?

☐ Yes ☐ No

Do you carry an epinephrine auto-injector (EpiPen®)?

☐ Yes ☐ No

If you carry an epinephrine auto-injector, please ensure it remains accessible to you at all times during the activity.

Respiratory Conditions

Do you have asthma or any other breathing-related condition?

☐ Yes ☐ No

If yes, please provide details:

Do you use an inhaler?

☐ Yes ☐ No

Diabetes

Do you have diabetes?

☐ Yes ☐ No

If yes, please describe any medications, supplies, or support you may require during the activity:

Heart or Cardiac Conditions

Do you have any heart-related or cardiac conditions?

☐ Yes ☐ No

If yes, please provide details:

Medical Alert Identification

Do you wear a MedicAlert® bracelet, necklace, or other medical identification?

☐ Yes ☐ No

If yes, please indicate what it says and where it is worn:

Immunizations

Date of most recent tetanus vaccination (if known):

Vision

Do you wear contact lenses?

☐ Yes ☐ No

Blood Type (Optional)

Medications

Please list any medications, including prescription and non-prescription medications, that you may need while participating in this activity.

Do any of these medications require specialized storage or handling?

☐ Yes ☐ No

If yes, please provide details:

Medical Conditions, Accessibility Needs, or Physical Limitations

Please tell us about any health conditions, injuries, accessibility needs, physical limitations, or other concerns that may affect your participation in this activity. This information helps us plan for your safety and support your success.

Additional Information

Please provide any other information you would like staff to be aware of: