

# PHYSICIAN'S FORM 2018-2019

L'ÉCOLE  
NATIONALE DE  
**BAJLET**  
DU CANADA

CANADA'S  
NATIONAL  
**BAJLET**  
SCHOOL

➤ A NEW FORM MUST BE COMPLETED EACH YEAR

➤ STUDENTS WILL NOT BE PERMITTED TO ATTEND CLASS UNTIL THIS FORM HAS BEEN FULLY COMPLETED AND RETURNED TO CANADA'S NATIONAL BALLET SCHOOL (NBS)

Parents: When completed, email to: [registrar@nbs-enb.ca](mailto:registrar@nbs-enb.ca).

## Physical Examination – TO BE COMPLETED AND SIGNED BY A PHYSICIAN

*In the event that you cannot obtain an appointment with your family physician, we do accept forms completed by a physician from a walk-in clinic or a nurse practitioner.*

Student's Name:

First Finnian

Middle Patrick

Last Hepting

Date of Birth:

09/01/2002  
MM/DD/YYYY

Height:

5ft 1

Weight:

Please complete as appropriate and qualify where necessary on a separate page.

Does the student have medical problems? (For example: asthma or diabetes.) Please list:

no

If the student is taking medications of any kind, please list and explain when and how to administer. Include any supplements or non-prescribed medications being taken (for example: multivitamins, acetaminophen, or ibuprofen.)

*Medications must be brought to NBS by the student; residence students must hand in all medication to residence staff.*

Name of medication

Dosage or As Needed

Reason for taking medication

Name of medication

Dosage or As Needed

Reason for taking medication

Name of medication

Dosage or As Needed

Reason for taking medication

## ALLERGIES/SPECIAL DIET

Please identify any life-threatening allergies and treatment required:

Allergen

Treatment

Allergen

Treatment

Does the student require an EpiPen/Twinject (epinephrine autoinjector) or other specialized treatment for an allergic reaction?

☐ Yes ☒ No

Does the student know how to self-administer the treatment?

☐ Yes ☐ No

Please list any other allergens to avoid and/or diet required to keep this student in good health:

Drug:

Food:

Environmental:

Special Diet:

Student's Name:

Kianan Patrick Hepting

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**MEDICAL HISTORY**

Please check if the student has had any of the following and provide dates:

<input type="checkbox"/> Bed Wetting	MM/DD/YYYY	<input type="checkbox"/> Hay Fever	MM/DD/YYYY	<input type="checkbox"/> Severe Stomach Ache	MM/DD/YYYY
<input type="checkbox"/> Chicken Pox	MM/DD/YYYY	<input type="checkbox"/> Heart Condition	MM/DD/YYYY	<input type="checkbox"/> Sinus Trouble	MM/DD/YYYY
<input type="checkbox"/> Diabetes	MM/DD/YYYY	<input type="checkbox"/> Hepatitis	MM/DD/YYYY	<input type="checkbox"/> Sleep Walking	MM/DD/YYYY
<input type="checkbox"/> Dizzy Spells	MM/DD/YYYY	<input type="checkbox"/> Mononucleosis	MM/DD/YYYY	<input type="checkbox"/> Tuberculosis	MM/DD/YYYY
<input type="checkbox"/> Frequent Colds	MM/DD/YYYY	<input type="checkbox"/> Red Measles	MM/DD/YYYY	<input checked="" type="checkbox"/> Glasses/Contacts	2014 MM/DD/YYYY
<input type="checkbox"/> German Measles	MM/DD/YYYY	<input type="checkbox"/> Rheumatic Fever	MM/DD/YYYY	<input type="checkbox"/> Whooping Cough	MM/DD/YYYY

**HISTORY OF PHYSICAL INJURIES**

Please list any dance-related or other physical injuries sustained by this student:

2015	Osgood-Schlatter	Recurring? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
MM/DD/YYYY	Injury	Treatment
MM/DD/YYYY	Injury	Treatment
MM/DD/YYYY	Injury	Treatment
MM/DD/YYYY	Injury	Treatment

Does the student CURRENTLY have any injuries? Please explain and include what treatment is being received, if applicable:

MM/DD/YYYY	Injury	Treatment
MM/DD/YYYY	Injury	Treatment
MM/DD/YYYY	Injury	Treatment

Is the student currently receiving advice/treatment from a health care practitioner/other on a preventative basis? (For example, an osteopath, massage therapist, naturopath, or chiropractor.)

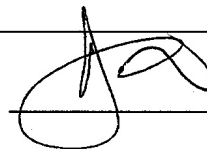
**> A copy of the student's MOST RECENT IMMUNIZATION RECORD MUST BE ATTACHED.**

To the best of my knowledge this student is in good health and is physically able to participate in all school and dance activities, with the following exception(s):

Physician's Name:

DR. AFAM NWAHUSI

Signature:



Date:

30/8/2018

**Address of Physician**

Office/Business Name:

Alliance Health Regan

Street Address:

8737 Wessex Parkway

City/Town:

Regan

Province/State:

SK

Postal Code/ZIP:

S4S 0A2

Country:

Canada

Telephone No:

3063373860

## Client Immunization Profile Record

Report as of Date / Time 2017 Dec 22 / 10:00

Next Immunization Date 2027 Aug 25

## Personal Information

Client ID 182959  
 Client Name HEPTING, FINNIAN  
 Date of Birth 2002 Sep 01

Health Card Number 773652132  
 Gender Male

## Immunization History

Based on our records, FINNIAN HEPTING has received the following immunizations

Immunizing Agent/Antigen	Immunization Date		
DTaP-IPV Diphtheria-Tetanus-acellular Pertussis-inactivated Poliovirus	2007 May 03		
DTaP-IPV-Hib Diphtheria-Tetanus-acellular Pertussis-inactivated Poliovirus-Haemophilus influenzae type b	2002 Nov 05	2003 Jan 02	2003 Feb 28 2004 Mar 03
H1N1-unspecified H1N1, unspecified	2009 Nov 18		
HB Hepatitis B	2017 Aug 25	2017 Dec 22	
Inf Influenza, injectable	2017 Dec 22		
Men-C-ACYW-135 Meningococcal Conjugate ACYW-135	2017 Aug 25		
Men-C-C Meningococcal Conjugate C	2007 May 03		
MMR Measles-Mumps-Rubella	2003 Sep 03	2004 Mar 03	
Tdap Tetanus-Diphtheria-acellular Pertussis	2017 Aug 25		
Var Varicella	2017 Aug 25	2017 Dec 22	