GREEK COMMUNITY SCHOOL - Adult Language Classes

Legal Surname: ______________________

Legal Given Name (s): ______________________

Address Line 1 ______________________

City/Town ____________ Province ____________ Postal Code: ____________

Home Phone Number: ____________ Other Number: (optional) ____________

E-mail: ______________________

Which class are you registering for? ______________________

Student Medical Information:

Health Care Number: ______________________

Additional Medical/Hospital Coverage Policy Number: ______________________

Family Doctor: ______________________ Phone #: ____________

Please indicate and medical condition we should be aware of:

- ☐ Arthritis
- ☐ Asthma
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Migraine Headaches
- ☐ Kidney Disease
- ☐ Other ____________

How do you usually treat these conditions? ______________________

Chronic conditions, recent illness or surgery of which the staff should be aware of:

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Please list ALL known allergies:

Allergy	Reaction	Treatment

Are you currently taking any medication staff should be aware of? ☐ Yes ☐ No

If yes, please list any medication to be taken or carried by the student:

Description of Medication	Illness	Dosage / Time Taken

Additional Information staff should be aware of: ______________________

Emergency Contact:

Name: ______________________ Relationship: ____________

Address: ______________________ Phone #: ____________

Date: ____________ Signature: ______________________

There will be no refunds for tuition after the first 2 classes.