

Student Medical Record

The information given on this form will be confidential. It is required to give the school knowledge of your child's medical status in the event of any illness or accident occurring at school.

Student's Name

Date of Birth

Contact Details **Father** **Mother**

Name

Cell phone

Address

Clinic to be contacted in case of emergency

Clinic Name

Cell phone

Doctor's Name

Doctor's Phone **Landline**

Cell phone

Person to be contacted if parents are not available

Name

Relationship

Phone **Landline**

Cell phone

Immunisation

BCG – Date Immunised

TETANUS – Date Immunised

Are there known eye problems? (please tick where applicable)

Glasses Contact Lenses

Special seating? Yes No

Under the care of Dr

Cell phone

Are there known ear problems? (please where applicable)

Hearing Aid Grommets Glue Ear

Special seating? Yes No

Under the care of Dr

Cell phone

Are there known speech problems?

Speech therapy

Orthopaedic problems

Limitations

Are there known heart problems?

Limitations

Medications

Are there other conditions?

ADD/ADHD

Medication name

Seizure disorder

Medication name

Asthma

Medication name

Allergies

Allergic to

Medication name

Allergic to

Medication name

Allergic to

Medication name

Bee stings: if applicable please give instructions if stung

Haemophilia: if applicable please give instructions if bleeding or injured

Diabetes: if applicable please indicate signs/symptoms of impending problem

Swimming

Swimming ability Weak Capable Good

Permission to swim under supervision? Yes No

Body data

Height in cm

Weight in kg

Dietary Restrictions (please tick where applicable)

Vegetarian Beef Seafood Haalal (incl. no pork)

Other significant illnesses, accidents, operations, limitations and medications

Please inform the school of any changes in your child's health status. The school cannot be held responsible for acting on information which has not been updated.

I give permission for qualified representatives of the school or external medical personnel to administer medical treatment to my child should the need arise.

Signed

Date