

**MEDICAL FORM**

The School's Health Office provides a First Aid service to all registered students during the school hours of operation and at school functions, while on campus. It is important to have current and accurate health information regarding your child's health and medical requirements. Please complete and submit this form at the time of registration. Should the health requirements or circumstances of your child change, please inform the school nurse in writing of any changes.

**Important:** All students must submit proof of full medical insurance, prior to admission.

Medical Insurance Card (type and number):  
\_\_\_\_\_

Name of Child: \_\_\_\_\_

Grade: \_\_\_\_\_

Gender: M / F

Date of birth: \_\_\_\_\_

Date of Form: \_\_\_\_\_

Blood group (if known):  
\_\_\_\_\_

Name of Parent/ Guardian:  
\_\_\_\_\_

Parent/ Guardian contact numbers, in case of emergency:

Home: \_\_\_\_\_

Office: \_\_\_\_\_

Mobile: \_\_\_\_\_

Alternative: \_\_\_\_\_

Child's Doctor: \_\_\_\_\_

Doctor's Tel: \_\_\_\_\_

Doctor's Mobile: \_\_\_\_\_

Please indicate whether your child has been inoculated against or has suffered from any of the following illnesses:

Illness	Inoculated	Date	Contracted	Date
Chicken Pox				
Measles				
German Measles				
Hepatitis				
Bilharzia				
Whooping Cough				
Mumps				
Malaria				
Glandular Fever				
Other				

Does your child suffer from any of the following conditions? If yes, please comment.

Condition	Yes/No	Comments
Eczema		
Bronchial Asthma		
Epilepsy		
Congenital Heart Disease		
Sinusitis		
Allergies		
Thalasaemia (Blood disorder)		
Rheumatic Fever		
Diabetes Mellitus		
Nocturnal Enuresis		
Vision Problems		
Hearing Problems		
Frequent Headaches		
Other		

Has your child ever been hospitalized or undergone an operation that you feel impacts their current health or well-being?

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**Emergency Treatment**

The school nurse will attempt to contact you should an emergency arise.

YES  NO

In the event parents cannot be contacted, I authorize and empower the school nurse or a school administrator to make any and all decisions concerning the medical and/or surgical care of the child, which may include taking the child to a doctor or hospital for emergency treatment.

**Consent for Medication**

If your child is unable to take certain medications, please contact the school nurse to discuss the use of an alternative medication.

YES  NO

The school has permission to give my child medication, should it be considered necessary by the school nurse. These medications are not readily given, but only after careful consideration.

I hereby certify that my child is physically fit to participate in all school activities on the campus, as well as, school events off campus. Also,

**Signature of Parent/ Legal guardian:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

(Please Print)

**PLEASE ADVISE THE SCHOOL NURSE IN WRITING OF ANY CHANGES TO THIS INFORMATION.**