



## REQUIRED HEALTH MEDICAL INFORMATION SY 2007-08

*Please complete one form for each child*

Pupil's name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle (dd/mm/yyyy)

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

Home phone number: \_\_\_\_\_

Parent's email address: \_\_\_\_\_

Which clinic/hospital does your family usually use? \_\_\_\_\_

Name of Doctor: \_\_\_\_\_ Tel \_\_\_\_\_

In case of an emergency, please indicate where the student's parents (or guardians) can be reached during school hours:

Mother's name: \_\_\_\_\_ Father's name: \_\_\_\_\_

Name of work place \_\_\_\_\_ Name of work place: \_\_\_\_\_

Phone: home: \_\_\_\_\_ home: \_\_\_\_\_

work: \_\_\_\_\_ work: \_\_\_\_\_

mobile: \_\_\_\_\_ mobile: \_\_\_\_\_

List two adults who are authorized to pick up your child/ren and who will be responsible for them if you cannot be reached (in an emergency):

Name 1: \_\_\_\_\_ Name 2: \_\_\_\_\_

home: \_\_\_\_\_ home: \_\_\_\_\_

work: \_\_\_\_\_ work: \_\_\_\_\_

mobile: \_\_\_\_\_ mobile: \_\_\_\_\_

## Medical Information

The following information is strictly confidential and will be shared only by the school nurse, the class teacher prior to school trips, and in the case of an emergency.

### Medical History

Please tick in the appropriate box to indicate if your child has a problem with any of the following:

<input type="checkbox"/>	Asthma, wheezing, chronic cough or other breathing difficulties	<input type="checkbox"/>	Diarrhea or stomach problems
<input type="checkbox"/>	Epilepsy, seizures, convulsions, or unexplained losses of consciousness	<input type="checkbox"/>	Heart problems
<input type="checkbox"/>	Orthopedic or back problems; or any condition which impairs full movement	<input type="checkbox"/>	Headaches, migraines
<input type="checkbox"/>	Allergies (e.g. to pollen, dust, insect bites, foods, chemicals, drugs etc.)	<input type="checkbox"/>	Sleeping difficulties
<input type="checkbox"/>	Life threatening allergic reactions	<input type="checkbox"/>	Emotional problems
<input type="checkbox"/>	Visual problems (squints, glasses, colour blindness, itchy or red eyes)	<input type="checkbox"/>	Abnormal bleeding
<input type="checkbox"/>	Ear problems (e.g. deafness, tinnitus, 'swimming ear', aches or infections)	<input type="checkbox"/>	Communicable diseases
<input type="checkbox"/>	Dietary restrictions (religious/medical)	<input type="checkbox"/>	Tropical diseases
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Urinary infections
<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>		<input type="checkbox"/>	Other

Please give additional information if you have indicated yes to any of the above:

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Does your child take any regular medication? If yes, please specify:

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Does your child need to bring this medicine to school?

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Has your child any medical condition which might interfere with his or her progress at school?

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Has your child been hospitalized for any reason since birth?

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Has your child had any operations or serious illnesses?

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Is there anything else about your child's health that is important for us to know?

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### Infectious Diseases

Please remember to keep sick children at home, especially if their illness is contagious. Contagious illness includes, but is not limited to, chicken pox, mumps, lice, scabies, conjunctivitis (red eye), impetigo, ring worm (unless covered), flu, upper respiratory infections e.g. phlegm coughs.

Please indicate if your child has had any one of the following:

<input type="checkbox"/>	Chicken pox
<input type="checkbox"/>	German measles
<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Measles
<input type="checkbox"/>	Whooping cough

### Immunization Record

Please indicate the dates of your child's vaccinations.

DPT	
Tetanus	
BCG (tine test)	
Measles	
Meningitis	
Polio: 1 <sup>st</sup> dose	
Polio: 2 <sup>nd</sup> dose	
Polio: 3 <sup>rd</sup> dose	
Polio: booster	

### Consent

The Health Room is run by the school nurse and offers care to children with minor injuries and illnesses. In the case of your child needing treatment during school hours would you be happy for your child:

<input type="checkbox"/>	<i>to have cuts and grazes cleaned and dressed?</i>
<input type="checkbox"/>	<i>be given Panadol, throat lozenges, cough medicines, eye drops etc.?</i>
<input type="checkbox"/>	<i>to have applied: antihistamine cream, burn cream etc.?</i>
<input type="checkbox"/>	<i>to have treated: sprains, insect bites, minor allergies etc.?</i>
<input type="checkbox"/>	<i>Would you like to be informed before treatment?</i>

The nurse will endeavor to inform parents as soon as possible in the case of any serious illness. If, however, we are unable to reach you or your child's guardians, are you willing for the school to transport your child to hospital?

Yes    No

**Please remember that it is your responsibility to report any health changes to the nurse as soon as they occur.**

Thank you very much for taking the time to fill in this form.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_