



Student Information and Health History

(to be completed by a parent or guardian)

Child's Name _____ Date of Birth _____ Grade _____

Citizenship _____	Passport No. _____
Phone Home _____	Phone Work _____
Mother's Mobile no. _____	Father's Mobile no. _____
Child's Doctor _____	Doctor's Phone no. _____
Medical Insurer _____	Insurance ID no. _____
Matriculation no. _____	
Emergency Contact _____	Phone no. _____
(In case parents cannot be reached)	

Authorisations

I hereby authorize the school nurse or delegated member of the school staff to administer basic First Aid or Emergency medical treatment to my child should it be required.

Date _____ Signature of parent _____

I authorize the school nurse to administer the following to my child [please check box (es)]:

- Antiseptic spray/cream for first aid
 Throat lozenges
 Dose appropriate non-aspirin pain reliever/fever reducer (e.g. Paracetamol/Tylenol)

Health History

Is your child currently under medical care <input type="checkbox"/> Yes <input type="checkbox"/> No If so for what condition? _____ Does your child have any restriction on physical activity <input type="checkbox"/> Yes <input type="checkbox"/> No
Illnesses (data and give any related information)
Allergies _____
Asthma _____
Rubella _____
Measles _____
Mumps _____
Scarlet Fever _____
Tonsillectomy _____
Adenoidectomy _____
Does your child routinely take medication? <input type="checkbox"/> yes <input type="checkbox"/> no Type _____ Time _____ Quantity _____ For what condition _____

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Student has or has had any of the following conditions, if so please explain with dates		
Allergies		
Asthma		
Cardiac disease		
Congenital problems		
Dental Problems		
Diabetes		
Ear Problems		
Hearing problems		
Emotional problems		
Eating Disorder		
Epilepsy / Seizures		
Gastrointestinal Problems		
Headaches		
Menstrual problems		
Motor Skills	Fine motor	Gross Motor
Orthopaedic problems		
Respiratory illness		
Skin trouble		
Urinary tract problems		
Serious accidents		
Hospitalisations		
Operations		
Other		
Date of last dental visit		
Date of last audiometric screening and result		

Immunization History	
Diphtheria _____	Mumps _____ Measles _____
Pertussis _____	Rubella _____
Tetanus _____	HIB _____
Polio (oral) _____	Meningitec c _____
Polio (inj.) _____	Tuberculosis (BCG) _____
Hepatitis B _____	Other _____

Does your child wear glasses: yes no Contact lenses: yes no

Vision Screening	Date	Both Eyes	Left	Right

Check one Normal Color Vision Abnormal Color Vision

Explain abnormalities _____