



PUPIL MEDICAL HEALTH FORM

CONFIDENTIAL

PUPIL NAME:	DATE OF BIRTH: <i>day</i> ____ <i>month</i> ____ <i>year</i> ____
PAEDIATRICIAN'S NAME:	TELEPHONE:
EMERGENCY CONTACT(S):	TELEPHONE(S):
1.	1.
2.	2.

THIS FORM MUST BE COMPLETED BY A DOCTOR/PAEDIATRICIAN

IMMUNISATION RECORD (Please indicate year of immunization or last booster)			
DT (Diphtheria/Tetanus) or DPT (Whooping Cough/ Diphtheria/Tetanus)	MMR (Measles, Mumps, Rubella)	Hepatitis A	Hepatitis B
BCG (Tuberculosis)	IPV (Polio)	Hib (Haemophilus Influenza Type B)	Pneumonocial
Meningitis	Mantoux		

MEDICAL HISTORY (Please check the ones (if any) that apply to this pupil providing details)

Heart Disease	Kidney Disease	Diabetes	Epilepsy/Convulsions
Tuberculosis	Hearing	Eye-Sight	Allergies

Can this pupil participate in all school activities, including swimming? (Separate paperwork will be required for swimming purposes) **Yes / No**

Doctor's Name, Signature and Stamp: _____

Date: _____

THIS SECTION MUST BE SIGNED BY THE PARENT/GUARDIAN

1. **Medications:** All medications to be given during school hours must be properly labeled. Instructions regarding dose and time must be clearly written and signed by parent/guardian or doctor.

Medication: _____ Condition: _____ Taken at school? **Yes / No**

2. **Parental Consent:** I give permission for my son/daughter to be given Depon (for headache, fever or sore throat) or Algofren/Advil (Ibuprofen) (for headache or fever). **Yes / No** **Dose:** _____

3. In the event that I cannot be reached I give my permission for the school to proceed with emergency medical treatment, if required. **Yes / No**

SIGNATURE OF PARENT OR GUARDIAN: _____ **DATE:** _____