Byron College
THE BRITISH INTERNATIONAL SCHOOL

PUPIL MEDICAL HEALTH FORM

CONFIDENTIAL

PUPIL NAME:	DATE OF BIRTH: *day*_____ *month* _____ *year* _____
PAEDIATRICIAN'S NAME:	TELEPHONE:
EMERGENCY CONTACT(S): 1. 2.	TELEPHONE(S): 1. 2.

THIS FORM MUST BE COMPLETED BY A DOCTOR/PAEDIATRICIAN

IMMUNISATION RECORD (Please indicate year of immunization or last booster)			
DT (Diptheria/Tetanus) or **DPT** (Whooping Cough/ Diptheria/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:** _____