

To enable our school to provide the best possible care to your child when they are injured or unwell, please spend a few minutes to complete the form and return it to our school. This information needs to be updated for extended trips such as school camps that may occur during the school year.

Part I : Personal Data

Student

Student Name : _____ Year/Class : _____

Age : _____ Gender : _____

Parents/Guardians

Name (1): _____ Name (2): _____

Relationship : _____ Relationship : _____

Telephone (H): _____ Telephone (H): _____

Telephone (O): _____ Telephone (O): _____

Mobile : _____ Mobile : _____

In case of Emergency, the above named parent(s)/guardian(s) will be contacted.

Part II : Medical Information

1. Does your child have any of the following medical conditions that may require EMERGENCY care? (please put a "√" in an appropriate box)

Medical condition	Yes	No
G6PD deficiency		
Joint problems		
Diabetes		
Tires easily		
Hypertension		
Convulsions/Epilepsy		
Kidney Disease		
Previous concussion or head injury		
Heart Conditions		
Rare Blood Type		
Previous serious injury		
Dizziness/Fainting spells		
Previous surgery		
Rheumatic fever		

Medical condition	Yes	No
Respiratory disorder		
Circulatory Problem		
Others (please specify)		

Other medical information	Yes	No
Frequent nose bleeds		
Psychological condition		
Hearing impairment		
Bed wetting		
Contact lens/glasses		
Travel sickness		

If YES, please give additional information: _____

2. Is your child currently taking long-term medication? YES* / NO*

If YES, please give additional information: _____

3. Has your child had a tetanus injection within the last 10years: YES* / NO*

If YES, please give additional information: _____

Allergies:

1. Does your child suffer from any allergies?

Allergy to	Name of allergen	Severe (i.e. Anaphylaxis)	Slight (i.e. Non life threatening)	None
Foods		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insects		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Animals		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasses, pollen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Describe what happens during a reaction: _____

3. In the event of a reaction, what actions are necessary: _____

4. Has hospitalization occurred because of a reaction : No Yes Date _____

5. Name of allergy medication _____

Asthma :

1. Does your child suffer from asthma ? YES* / NO*

2. Please indicate (circle) how severe your child's asthma is:

Mild	Moderate	Severe
Attacks are rare, limited mostly to tightness and wheezing	Occasional attacks which can be self managed using prescribed medication	Attacks are regular, severe and have required hospital treatment

3. When was your child's last asthma attack ? _____

4. Did your child require medical/hospital treatment ? YES* / NO*

5. Please list the triggers of your child's asthma attacks: _____

6. Details of medication to be administered in the event of an attack? _____

7. Is there any other information you feel we need to be aware of when caring for your child when hurt or sick?

Part III : Dietary information

Please outline below any special dietary requirements of your child and how best they should be catered for on an excursion.

Part IV : Medication Administration

Below is the school policy on the provision of medical services:-

1. Drug administration is subject to the production of a completed Medication Authorization Form and the prescribed drug/medication.
2. Except for the above, the school will not prescribe any medication/drug to student.

Part V : Declaration

I have completed this Medical Information Form accurately, truthfully, and to the best of my knowledge as of today's date. I understand that it is my responsibility to inform the school of any new medical condition or change in this information.

I hereby give consent and full authority for the staff or agents of the school to arrange for and consent to any medical treatment or hospitalization for my child while s/he is in the care of the school. I further authorize these staff members to enter into and execute, on my behalf, such documents or consents as may be required by medical Practitioners, Health Care Professionals or Hospitals for such purposes.

Signature of Parent / Guardian _____

Date _____