



BOARDING STUDENT MEDICAL INFORMATION

Please complete and return this form to the College.

STUDENT DETAILS:

SURNAME OF STUDENT: _____ FIRST NAMES: _____

RELIGION: _____

DATE OF BIRTH: _____ ID NUMBER: _____

CELL NUMBER: _____ GRADE: _____

PARENT CONTACT DETAILS:

FATHER'S NAME AND SURNAME: _____

BUSINESS PHONE/ CELL NO: _____

MOTHER'S NAME AND SURNAME: _____

BUSINESS PHONE/ CELL NO: _____

HOME ADDRESS: _____

HOME PHONE NO: _____ FAX NO: _____

E-MAIL ADDRESS: _____

LOCAL CONTACT FOR MEDICAL EMERGENCIES: _____ TEL NO: _____

LOCAL DOCTOR (IF ANY): _____ TEL NO: _____

MEDICAL AID DETAILS:

NAME OF FUND: _____ MEDICAL AID NO: _____

FULL NAME OF PRINCIPAL MEMBER: _____

I.D. NO OF PRINCIPAL MEMBER: _____ D.O.B OF PRINCIPAL MEMBER: _____

SUFFIX OF STUDENT (If applicable): _____

ALLERGIES:

	Yes	No	Treatment received
Asthma			
Bee Stings			
Food			
Medicine			
Other-			

MEDICAL PROCEDURES:

	Yes	No	Treatment received
Operations			
Fractures			

MEDICAL TREATMENT:

In the event of your child requiring an X-Ray for an injury, do you consent to the School having such carried out without prior reference to you? (tick the appropriate box)

Yes
No

MEDICAL AUTHORISATION:

In the event of a medical emergency involving your child, and where the College has been unsuccessful in contacting you, do you give the College the authority to authorise the necessary medical treatment?

I AGREE HERETO

I DO NOT AGREE HERETO

NAME OF GUARDIAN: _____

SIGNATURE OF GUARDIAN: _____ DATE: _____

ADMINISTRATION OF MEDICINES:

Please note that we are unable to dispense any form of medication to pupils without express written permission from parents.

We believe that in effectively managing a large school, we can assist the parents by making the following medications available:

Paracetamol tablets	Paracetamol syrup
Cleansing antiseptics	Antihistamine cream for stings and bites
Throat Lozenges	Elastoplast

We ask that you indicate the options to which you give your consent:

- Option A The school representative may make available and administer only the medicines as listed above. All medicine administered will be recorded.

- Option B The school representative may NOT administer any form of medication and must contact me should my child be ill.

- Option C I have given separate written permission for the administering of medication other than the medicines listed above. (allergies, bee stings, etc.)

I give consent for Option (s):

A B C

(tick the appropriate boxes)

INOCULATIONS / VACCINATIONS

Please indicate by marking the relevant block whether your child has been vaccinated against the FOLLOWING:

	YES	NO	IF YES, DATE LAST GIVEN.
TETANUS (T.T)			
HEPATITIS B			

ADDITIONAL REMARKS: _____

NAME OF PARENT / GUARDIAN: _____

SIGNATURE (PARENT/GUARDIAN): _____ DATE: _____

THE FOLLOWING SECTION MUST BE COMPLETED AND SIGNED BY YOUR DOCTOR:

NAME OF STUDENT: _____

A. HISTORY

1. DOES THE STUDENT HAVE ANY SIGNIFICANT PAST MEDICAL HISTORY?

2. DOES THE STUDENT REQUIRE REGULAR MEDICATION?

3. IS THERE A HISTORY OF ALLERGY TO ANY DRUG?

4. IS THERE ANY REASON WHY THE STUDENT SHOULD NOT PARTICIPATE IN SPORT?

5. IS THERE ANY PAST ORTHOPAEDIC HISTORY?

6. HAS THE STUDENT HAD ANY LEARNING DIFFICULTIES IN THE PAST?

7. HAS THE STUDENT EVER BEEN TREATED FOR PSYCHOLOGICAL AND / OR EMOTIONAL PROBLEMS?

B. MEDICAL EXAMINATION

1. HEIGHT: _____ WEIGHT: _____

2. EYESIGHT: _____ L /6 R /6

3. E/N/T SYSTEM: _____ IS HEARING NORMAL: _____

4. CARDIOVASCULAR SYSTEM: _____

5. RESPIRATORY SYSTEM: _____

6. ABDOMEN: _____

7. CENTRAL NERVOUS SYSTEM: _____

8. GENITO-URINARY SYSTEM: _____

9. URINALYSIS: ALBUMIN: _____

GLUCOSE: _____

BLOOD: _____

NAME OF MEDICAL PRACTITIONER: _____

ADDRESS: _____

TELEPHONE: _____

SIGNATURE: _____