STUDENT MEDICAL FORM

STUDENT'S NAME ______________________________ AGE ________ CLASS ______________

ADDRESS ____

PHONE
MOTHER: HOME ____________________ WORK ____________________ MOBILE ____________________

FATHER: HOME ____________________ WORK ____________________ MOBILE ____________________

CONTACT NAME IN CASE OF EMERGENCY ________________________ RELATIONSHIP ____________________
(OTHER THAN THE PARENT)

PHONE: HOME ____________________ WORK ____________________ MOBILE ____________________

FAMILY DOCTOR ____

ADDRESS ____

PHONE ________________________________ EMERGENCY PHONE ________________________________

MEDICAL CONDITIONS - THE SCHOOL SHOULD BE AWARE OF ANY MEDICAL CONDITIONS PRESENTLY AFFECTING YOUR CHILD. PLEASE DESCRIBE THESE BELOW, AND ADD ALL THE NECESSARY INFORMATION.
E.G. ALLERGIC TO BEE STINGS. NEEDS IMMEDIATE MEDICATION.

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1. I CONSENT TO THE SCHOOL AUTHORITIES SEEKING AMBULANCE ASSISTANCE FOR MY CHILD IF THE AUTHORITIES DEEM IT NECESSARY. IT IS UNDERSTOOD THAT NO MEDICAL OR DENTAL ASSISTANCE CAN BE CARRIED OUT WITHOUT THE PARENTAL/LEGAL GUARDIAN PERMISSION.

2. I CERTIFY THAT MY CHILD DOES NOT TO MY KNOWLEDGE SUFFER FROM ANY ILLNESS OR DISABILITY WHICH MIGHT INTERFERE WITH OR INHIBIT ANY SUCH MEDICAL OR DENTAL TREATMENT EXCEPT FOR THE FOLLOWING:-

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I WILL NOTIFY THE SCHOOL IN WRITING IF ANY SUCH ILLNESS OR DISABILITY COMES TO MY KNOWLEDGE AT ANY TIME.

3. HAS YOUR CHILD BEEN IMMUNISED AGAINST MEASLES? YES / NO

4. HAS YOUR CHILD HAD A TETANUS INJECTION? YES / NO

IF MEDICATION MUST BE ADMINISTERED BY THE STUDENT HIM/HERSELF, OR BY A STAFF MEMBER DURING SCHOOL HOURS (8.30AM-3.00PM), YOU ARE REQUIRED TO COMPLETE THE SECTION ON THE BACK.

SIGNED ________________________________ DATE ____________________________
(Parent / Guardian)

STUDENT MEDICATION REQUEST / RECORD

Where possible student medication should be administered by the parent/guardian at home rather than at school. As this is not possible in all instances, should the Principal approve school staff to administer prescribed medication to students, the following requirements are to be met.

The doctor prescribing the medicine is to be aware that school staff will administer or supervise the administering of medication of students.

The doctor is to provide any additional information to staff regarding special requirements that may exist for the administration of the medication.

Prescribed student medication is to be presented to the Principal, and should be stored in a container clearly showing the name of the student, the name of the medication, the dosage and frequency.

I ____________________________________ being the parent / guardian of

____ Class _________
(name of student)

request that St Anthony's School administer the following medication as prescribed by

Dr ____ for the purpose of treating

____
(condition)

Name of medication ____

Dose ______________________________

Time to be taken _____________________

Comments ____

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SIGNED _____________________________________ DATE ________________
(Parent / Guardian)