

MEDICAL CONSENT FORM

The school's Health Office provides a First Aid service to all registered students during the school hours of operation and at school functions, while on campus. It is important to have current and accurate health information regarding your child's health and medical requirements. Please complete and submit this form at the time of registration. Should the health requirements or circumstances of your child change, please inform the school nurse in writing of any changes.

Important: All students must submit proof of full medical insurance, prior to admission.
Medical Insurance Card Number

Name of child: _____

Grade: _____ Gender: M / F

Date of birth: _____ Date of form: _____

Blood group: _____

Name of Parent/ Guardian:

Contacts numbers in case of emergency:

Please indicate whether your child has been inoculated against or has suffered from any of the following illnesses:

Illness	Inoculated	Contracted
Chicken Pox		
Measles		
Hepatitis		
Bilharzia		
Whooping Cough		
Mumps		
Malaria		
Glandular Fever		

Please check here if you want to discuss confidential information with the school nurse or other school authority.

Yes

No

If applicable, please provide the following information:

	Name	Phone	Date of Last Appointment
Family pediatrician			
Family specialist			
Family dentist			

Emergency Treatment

The school nurse will attempt to contact you should an emergency arise.

In the event parents cannot be contacted, I authorize and empower the school nurse or a school administrator to make any and all decisions concerning the medical and/ or surgical care of the child, which may include taking the child to a doctor or hospital for emergency treatment.

Yes

No

Consent for medication

If your child is unable to take certain medications, please contact the school nurse to discuss the use of alternative medication.

The school has permission to give my child medication, should it be considered necessary by the school nurse. These medications are not readily given, but only after careful considerations.

Yes

No

Name: _____

Signature: _____

Date: _____

PLEASE ADVISE THE SCHOOL NURSE IN WRITING OF ANY CHANGES TO THIS INFORMATION.