STUDENT MEDICAL RECORD

STUDENT NAME:	DATE OF BIRTH (DD/MM/YY):	GENDER: M☐ F☐	GRADE:
MOTHER'S NAME:	FATHER'S NAME:		

MEDICAL HISTORY *Does your child have any of the following conditions?* **MEDICATION PERMISSION** *Please tick.*

Asthma? Yes☐ No☐ Inhaler? Yes☐ No☐	Paracetamol	Yes☐	No☐
Epilepsy? Yes☐ No☐	Ibuprofen	Yes☐	No☐
Diabetes? Yes☐ No☐	Antihistamine Liquid/Tablets	Yes☐	No☐
Heart problems? Yes☐ No☐	Feminax (12yrs up)	Yes☐	No☐
A Medical condition or disability?	Antacid Tablets	Yes☐	No☐
Major medical illnesses or surgery?	Cough/Sore Throat Lozenge	Yes☐	No☐
Allergies?	Antiseptic Creams	Yes☐	No☐
To food? Yes☐ No☐	Cold/Flu Capsules (12yrs up)	Yes☐	No☐
To medicines? Yes☐ No☐	Honey & Lemon Linctus	Yes☐	No☐
To insect bites/stings? Yes☐ No☐	Arnica Cream	Yes☐	No☐
To plants/pollens? Yes☐ No☐			
Other? Yes☐ No☐			
Other concerns/conditions?			

PRESCRIBED MEDICATIONS:

Immunisation Record

Which country's immunisation schedule do you follow? ……

Please list dates of all immunisations:

IMMUNISATION	DATE #1	DATE #2	DATE #3	DATE #4	DATE #5	DATE #6
BCG						
Mantoux/PPD Test						
Diphtheria						
Pertussis						
Tetanus						
Oral/IPV Polio						
Measles						
Mumps						
Rubella						
HIB						
Hepatitis A						
Hepatitis B						
MenC						
H.P.V.						
PCV (Pneumonia)						
Varicella						

Does your child have any concerns related to:

Development **Yes** ☐ **No** ☐

Growth **Yes** ☐ **No** ☐

Behaviour **Yes** ☐ **No** ☐

Co-ordination **Yes** ☐ **No** ☐

Speech **Yes** ☐ **No** ☐

Vision **Yes** ☐ **No** ☐

Colour Vision **Yes** ☐ **No** ☐

Hearing **Yes** ☐ **No** ☐

Other information you feel may be of assistance to school.

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If you wish to discuss any concerns or queries please contact the school nurse.

I hereby authorise the School Nurses, First-Aiders or authorised members of the school staff to administer basic first aid treatment to my child. In the event my child is injured or becomes seriously ill while under school supervision and immediate medical treatment is necessary to preserve my child's health, I authorise the staff member in charge to act on my behalf. I will inform the school as soon as possible of any changes in medical or other relevant circumstances. I certify that all information given on this form is complete and correct.

Signature of Parent/Guardian: _____ Print Name: _____ Date: _____