

ST ANDREW'S INTERNATIONAL HIGH SCHOOL

Medical Form - Confidential

Section 1: Particulars of Student

Surname:		Forename(s):		
Date of Birth:		Sex:	M / F *	House:
Date of Admission:		Family Doctor Name:		
Medical Aid Name:		Medical Aid Number:		

* Please circle M/F

Section 2: Emergency Contact Details

Contact	Name	Home Telephone	Work Telephone	Mobile
Mother:				
Father:				
Guardian:				

Section 3: Medical History

Childhood Illnesses				
	Suffered		Inoculated	
Chickenpox:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Measles:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mumps:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Whooping Cough:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inoculations: Has your child been inoculated against the following?				
	Inoculated		Year of Inoculation	
Tetanus:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Tuberculosis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Chronic Illness: Does your child suffer from any of the following?				
Abnormal blood pressure:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dyslexia or specific learning difficulty:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Condition:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Problems:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of last eye test:	
Fainting:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tonsillitis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nose bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin Complaints:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If yes, please specify.)	
Allergies:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If yes, please specify.)	

SEN- Dyslexia/Slpd Hearing impaired Visually impaired Other	Follow up from previous school	
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes , please specify details and treatment your child uses below:
Does your child take any medication for long term conditions? (asthma inhalers, insulin pens, allergic pens)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify below
If your child is on treatment for a particular illness and will be required to take a mid-day dose please Notify the School Nurse		
Does your child take any form of malaria prophylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which one?

Section 4: Family History

Are you a one-parent family?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you, or is your spouse, a step-parent?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you adoptive parents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have there been any recent bereavements that may be distressing your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Answers to the above questions enable us to be sensitive and tactful when dealing with students in stressful situations. Please supply as much information as you can. Much of the information requested here will help the school clinic and other medical practitioners to administer the right treatment more quickly in the case of **MEDICAL EMERGENCIES**.

In cases beyond the scope of the clinic, the school normally takes students to Mwaiwathu Hospital. Parents are required to reimburse the school for medical expenses thus incurred. Please sign below if you agree to this arrangement.

I _____ agree to reimburse St Andrew's International High School fully for any medical expenses incurred by my child at Mwaiwathu Hospital Blantyre/specify hospital of choice. _____

If you do not agree, please specify in writing an alternative arrangement for your child in the event of medical emergency.

Signed:		Date:	
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Thank you for your help.

Saint Andrew's International High School