

STUDENT'S HEALTH RECORD – 2012

**PLEASE COMPLETE THE FOLLOWING IN BLOCK CAPITALS (If applicable, please underline custodial parent)
(Completion of this form is a requirement of the Application Process but does not guarantee a confirmed place)**

Homeroom: _____

STUDENT'S SURNAME _____ FIRST NAMES _____

STUDENT'S DATE OF BIRTH _____

Mother's Name _____ Home Tel. No. _____ Work Tel. No. _____

Father's Name _____ Home Tel. No. _____ Work Tel. No. _____

DOCTOR: _____ Surgery Tel. No. _____

Alternative contact (other than parents): _____ Tel. No. (Day) _____

(Relationship to student): _____

Does your son have (or has ever suffered from) any of the following:

(Please <u>TICK</u> the appropriate box)	<u>YES</u>	<u>NO</u>	Medication required at present:
ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic reaction to: Stings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic reaction to: Food	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic reaction to: Medication	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic reaction to: Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood-borne viruses (e.g. Hepatitis, HIV)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glandular Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

	<u>YES</u>	<u>NO</u>	
Does he suffer from any other medical condition or disability? (Hearing / Vision / Speech)	<input type="checkbox"/>	<input type="checkbox"/>	(Please state the condition or disability) _____ _____
Has he ever had major surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has he previously suffered from serious concussion?	<input type="checkbox"/>	<input type="checkbox"/>	(Details) _____ _____
Does he take any medication on a regular basis not previously stated?	<input type="checkbox"/>	<input type="checkbox"/>	(Please list medication) _____ _____

<u>VACCINATIONS:</u>	Has your son had the following:	<u>Year of Vaccination</u>	
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles / Mumps / Rubella (MMR)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Whooping Cough / Polio / Diphtheria (DPCH)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are you agreeable to your son receiving Panadol or other appropriate non-prescription medication if considered necessary by the Health Centre Staff? YES NO

Are you agreeable to your son receiving Brufen, or similar, as an anti-inflammatory medication if considered necessary by the Health Centre Staff? YES NO

Are you agreeable to your son receiving professional Physiotherapy on site, if considered necessary by the Health Centre Staff? YES NO

BLOOD TYPE – Your son’s Blood Type (if known) _____

Any further comment you may wish to add: _____

SPECIAL MEDICATION SHOULD BE LEFT WITH MATRON AT THE HEALTH CENTRE

The above information is requested in order to provide the College/Hostel with appropriate medical knowledge relating to your child and the means to make contact, if necessary. It will not be used for any other purpose. If the College/Hostel is unable to make contact with those named above in an emergency, the College/Hostel will seek appropriate medical assistance.

You are requested to sign this form giving permission, in case of an emergency, for this information to be passed on to a Doctor or hospital, for the College/Hostel to seek medical advice and also indicating your acceptance of the responsibility to reimburse the College/Hostel for reasonable costs incurred.

Parents’ signatures: _____
Mother
Father

Principal’s/Dean’s signature: _____ Date: _____

PLEASE RETURN THIS FORM WITH YOUR APPLICATION FORM