STUDENT'S HEALTH RECORD – 2012

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

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	☐	☐	______________________________
Allergic reaction to: Stings	☐	☐	______________________________
Allergic reaction to: Food	☐	☐	______________________________
Allergic reaction to: Medication	☐	☐	______________________________
Allergic reaction to: Other (Specify)	☐	☐	______________________________
Asthma	☐	☐	______________________________
Appendicitis	☐	☐	______________________________
Blood-borne viruses (e.g. Hepatitis, HIV)	☐	☐	______________________________
Chicken Pox	☐	☐	______________________________
Diabetes	☐	☐	______________________________
Epilepsy	☐	☐	______________________________
Glandular Fever	☐	☐	______________________________
Hay Fever	☐	☐	______________________________
Hepatitis	☐	☐	______________________________
Migraine	☐	☐	______________________________
Rheumatic Fever	☐	☐	______________________________
Tonsillitis	☐	☐	______________________________
Tuberculosis	☐	☐	______________________________

	YES	NO	
Does he suffer from any other medical condition or disability? (Hearing / Vision / Speech)	☐	☐	**(Please state the condition or disability)**______________________________ ______________________________
Has he ever had major surgery ?	☐	☐	______________________________
Has he previously suffered from serious concussion?	☐	☐	**(Details)**______________________________ ______________________________
Does he take any medication on a regular basis not previously stated?	☐	☐	**(Please list medication)**______________________________ ______________________________

VACCINATIONS: Has your son had the following:

			Year of Vaccination
Hepatitis B	☐	☐	______________________________
Measles / Mumps / Rubella (MMR)	☐	☐	______________________________
Tetanus	☐	☐	______________________________
Tuberculosis	☐	☐	______________________________
Whooping Cough / Polio / Diphtheria (DPCH)	☐	☐	______________________________

Are you agreeable to your son receiving Panadol or other appropriate non-prescription medication if considered necessary by the Health Centre Staff? ☐ ☐

Are you agreeable to your son receiving Brufen, or similar, as an anti-inflammatory medication if considered necessary by the Health Centre Staff? ☐ ☐

Are you agreeable to your son receiving professional Physiotherapy on site, if considered necessary by the Health Centre Staff?

☐ ☐

BLOOD TYPE – Your son's Blood Type (if known) ______________________________

Any further comment you may wish to add: ______________________________

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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