Student Medical Information Form

St Paul Rongo Mixed Secondary School

Confidential Medical Form  
This information is kept strictly confidential and is used to ensure the safety and well-being of your child while at school.

# SECTION 1: STUDENT INFORMATION

Full Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: ☐ Male ☐ Female ☐ Other

Class/Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Admission Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# SECTION 2: PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternative Contact (Name & Phone): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# SECTION 3: MEDICAL HISTORY

1. Does your child have any allergies (e.g., food, medicine, insects)? ☐ Yes ☐ No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Does your child have any chronic medical conditions? (e.g., asthma, epilepsy, diabetes) ☐ Yes ☐ No

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Is your child currently taking any medication? ☐ Yes ☐ No

If yes, please list medication and dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Has your child been hospitalized in the past year? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# SECTION 4: IMMUNIZATION RECORD

|  |  |
| --- | --- |
| Vaccine | Date Received |
| BCG | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Polio | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DPT (Diphtheria, etc.) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Measles/Mumps/Rubella | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hepatitis B | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Others (specify) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

# SECTION 5: EMERGENCY MEDICAL CONSENT

In the event of an emergency, I give permission for my child to receive medical treatment by a licensed physician or first responder.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# SECTION 6: SCHOOL NURSE/OFFICE USE ONLY

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Follow-up Required: ☐ Yes ☐ No

Date Reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_