THIS SECTION TO BE COMPLETED BY A QUALIFIED DOCTOR

Child's Name: …….

Date of Birth: …… Grade: ……..

MEDICAL HISTORY	FINDINGS	REMARKS
Chronic Diseases		
Infectious Diseases		
Allergies		
Surgical Procedures		
Behavioural Problems (tics, enuresis, sleep problems)		
Learning Disabilities (dyslexia, learning or language difficulties)		
After Exercise (tires easily, chest pain, passing out)		
Other		

HEALTH EXAMINATION	NORMAL	ABNORMAL FINDINGS	REFERRAL
HEIGHT			
WEIGHT			
SKIN/APPEARANCE			
HEAD/SCALP			
NOSE/THROAT			
CHEST/LUNGS			
HERNIA			
MUSCULOSKELETAL			
Scoliosis			
Other			
EYE EXAM			
Right eye			
Left eye			
Strabismus			
Colour Blindness			
HEARING EXAM			
Right ear			
Left ear			
DENTAL EXAM			
HEART EXAM			
Circulation			
Blood Pressure			
Pulses			
Murmur			
OTHER FINDINGS			

IMMUNIZATION RECORD (Submit copy of record **or** give **YEAR** of last booster)			
Diptheria/Pertussis/Tetanus		Hepatitis A	
Polio		Hepatitis B	
Measles/Mumps/Rubella		Meningitis	
Chicken Pox		Pneumococcal	
Influenza		Other	

This child may participate in all school activities including swimming. Yes / No

This child has the following physical limitations. ……

Doctor's Name (*print*) …….

Signature/Stamp …….. Date ……...

CAMPION SCHOOL

PUPIL MEDICAL HEALTH FORM

CONFIDENTIAL

THIS SECTION TO BE COMPLETED BY CHILD'S PARENT

Child's Name: ..... Date of Birth: ……. □ Male □ Female

Address: ……..

Home Tel: ……. Email: …….

Emergency Contacts 1. …….. Tel: ……..

2. …….. Tel: ……..

Child's Doctor: …… Tel: ……..

A. MEDICAL HISTORY: Check the ones that apply to your child and describe in more detail in the comment section below.

____ Attention Problems
____ Anxiety/ Panic Attack
____ Asthma
____ Bee Sting Allergy
____ Bowel problem
____ Cerebral Palsy
____ Chicken Pox
____ Colour Blindness
____ Communication problems
____ Diabetes
____ Ear infection
____ Emotional concerns
____ Headaches
____ Hearing problem
____ Heart Condition
____ Infectious diseases
____ Kidney/urinary
____ Low birth weight (below 2500 grams/5lbs 8oz)
____ Muscle disorders
____ Neurological issues
____ Nose bleeds
____ Needs Anapen/epipen
____ Orthopeadic problem
____ Vision problem
____ Seizures/epilepsy
____ Surgery _____
____ Wears Glasses/Contact lenses

PE Activity:
____ Limited
____ Not Limited

Comments: …….

……..

B. ALLERGIES: Please indicate any allergies your child has (ie: food, medication, environmental)

Cause of allergy: …… Treatment: ……

Cause of allergy: …… Treatment: ……

Has your child ever been hospitalized because of a serious allergic reaction? Yes / No

C. MEDICATIONS: Include prescription, inhalers and homeopathic medications.

****ALL MEDICATIONS TO BE GIVEN DURING SCHOOL HOURS MUST BE PROPERLY LABELLED. INSTRUCTIONS REGARDING DOSE AND TIME MUST BE CLEARLY WRITTEN AND SIGNED BY PARENT OR DOCTOR. ****

	Medication	Condition	Taken at school?
1.	…….	…….	Yes / No
2.	…….	…….	Yes / No

D. PARENTAL CONSENT: (At the school's discretion) I give permission for my son/daughter to be given:

Depon (paracetamol) for:
Headache Yes / No
Sore throat Yes / No
Fever Yes / No

Advil (ibuprofen) for:
Menstrual pain Yes / No
Fever Yes / No

Cough Medicine (Sinecod) Yes / No

Throat Lozenges (Strepcils) Yes / No

In the event that I cannot be reached I give my permission for the school to proceed with emergency medical treatment, if required. Yes / No

Signature: …… **Date:** ……..