Somerset College

BOARDING STUDENT MEDICAL INFORMATION

Please complete and return this form to the College.

STUDENT DETAILS:

Surname of Student: _______________________________ First Names: _______________________________________

Religion: ____

Date of Birth: _______________________________ I.D. Number: _____________________________________

Cell Number: _______________________________ Grade: ____

PARENT CONTACT DETAILS:

Father's Name and Surname: ____

Business Phone / Cell No.: ____

Mother's Name and Surname: ____

Business Phone / Cell No.: ____

Home Address: ____

____

Home Phone No.: __________________________________ Fax No.: ______________________________________

E-Mail Address: ____

Local Contact for Medical Emergencies: __________________________________ Tel No.: ___________________________

Local Doctor (if any): _____________________________________ Tel No.: _____________________________________

MEDICAL AID DETAILS:

Name of Fund: ____ Medical Aid No: ___________________________________

Full Name of Principal Member: ____

I.D. No. of Principal Member: ___________________________ D.O.B of Principal Member: ________________________

Suffix of Student (if applicable): ____

ALLERGIES:

	Yes	No	Treatment Received
Asthma			
Bee Stings			
Food			
Medicine			
Other -			

MEDICAL PROCEDURES:

	Yes	No	Treatment Received
Operations			
Fractures			

MEDICAL TREATMENT:

In the event of your child requiring an X-Ray for an injury, do you consent to the School having such carried out without prior reference to you? (tick the appropriate box)

Yes
No

MEDICAL AUTHORISATION:

In the event of a medical emergency involving your child, and where the College has been unsuccessful in contacting you, do you give the College the authority to authorise the necessary medical treatment?

I AGREE HERETO	
I DO NOT AGREE HERETO	

NAME OF GUARDIAN: ____

SIGNATURE OF GUARDIAN: ______________________________ DATE: ______________________

ADMINISTRATION OF MEDICINES:

Please note that we are unable to dispense any form of medication to pupils without express written permission from parents.

We believe that in effectively managing a large school, we can assist the parents by making the following medications available:

Paracetamol tablets	Paracetamol syrup
Cleansing antiseptics	Antihistamine cream for stings and bites
Throat Lozenges	Elastoplast

We ask that you indicate the options to which you give your consent:

Option A The school representative may make available and administer only the medicines as listed above. All medicine administered will be recorded.

Option B The school representative may NOT administer any form of medication and must contact me should my child be ill.

Option C I have given separate written permission for the administering of medication other than the medicines listed above. (allergies, bee stings, etc.)

I give consent for Option (s): A B C (tick the appropriate boxes)

INNOCULATIONS / VACCINATIONS

Please indicate by marking the relevant block whether your child has been vaccinated against the FOLLOWING:

	YES	NO	IF YES, DATE LAST GIVEN
TETANUS (T.T)			
HEPATITIS B			

ADDITIONAL REMARKS: ____

____

____

NAME OF PARENT / GUARDIAN: ____

SIGNATURE (PARENT/GUARDIAN): ______________________________ DATE: __________________________

THE FOLLOWING SECTION MUST BE COMPLETED AND SIGNED BY YOUR DOCTOR:

NAME OF STUDENT: ____

A. HISTORY

1. DOES THE STUDENT HAVE ANY SIGNIFICANT PAST MEDICAL HISTORY?

____

____

____

2. DOES THE STUDENT REQUIRE REGULAR MEDICATION?

____

____

3. IS THERE A HISTORY OF ALLERGY TO ANY DRUG?

____

____

____

4. IS THERE ANY REASON WHY THE STUDENT SHOULD NOT PARTICIPATE IN SPORT?

____

____

____

5. IS THERE ANY PAST ORTHOPAEDIC HISTORY?

____

____

6. HAS THE STUDENT HAD ANY LEARNING DIFFICULTIES IN THE PAST?

____

____

7. HAS THE STUDENT EVER BEEN TREATED FOR PSYCHOLOGICAL AND / OR EMOTIONAL PROBLEMS?

____

____

____

B. **MEDICAL EXAMINATION**

1. HEIGHT: ___________________________________ WEIGHT: ______________________________________
2. EYESIGHT: __________________________________ L /6 R /6
3. E/N/T SYSTEM: ______________________________ IS HEARING NORMAL: ____________________________
4. CARDIOVASCULAR SYSTEM: ____
5. RESPIRATORY SYSTEM: ____
6. ABDOMEN: ____
7. CENTRAL NERVOUS SYSTEM: ____

   ____
8. GENITO-URINARY SYSTEM: ____

   ____
9. URINALYSIS: ALBUMIN: ____

   GLUCOSE: ____

   BLOOD: ____

NAME OF MEDICAL PRACTITIONER: ____

ADDRESS:____

____

TELEPHONE: ____

SIGNATURE: ____