

# Student Medical Information Form

To be completed and returned by all new-incoming students

Student Name \_\_\_\_\_

Year \_\_\_\_\_ (eg 1st yr)

Date of birth \_\_\_\_\_

Emergency contact name(s) \_\_\_\_\_

Emergency contact Tel nos: \_\_\_\_\_

\_\_\_\_\_

Family G.P: \_\_\_\_\_

Tel No: \_\_\_\_\_

## Medical History

(Major Illness/ Hospital Admissions/ Diabetes/ Asthma/ Epilepsy Etc)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Surgical History:

(Operations/ Broken Bones Etc....)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medications:

(Frequency and dose including Inhalers)

\_\_\_\_\_

\_\_\_\_\_

## Allergies:

(Drugs/ Food/ Other)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

P.T.O

## Vaccination History

Has your child been vaccinated for the following?

If yes, please tick the relevant boxes

	Date (if known)
BCG (TB) _____	_____
Mumps _____	_____
German Measles (Rubella) _____	_____
Chicken Pox _____	_____
Whooping Cough (Pertussis) _____	_____
Tetanus _____	_____
Hib _____	_____
Meningitis C _____	_____
Diphtheria _____	_____
Hepatitis B _____	_____

When approximately did your child last have a tetanus booster?

\_\_\_\_\_

I the undersigned agree to the release of the above information to Medical Professionals/ Teachers, as required in acute medical situations.

Signature of Parent/ Guardian

\_\_\_\_\_

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