SOUTHCITY CHRISTIAN SCHOOLS

Medical Health Record

Pupil Details:

Surname: _____ First Names: _____

Date of Birth: _____ I D Number: _____

Medical Aid Details: (Copies of Medical Aid Card and Main Member ID MUST be attached)

Medical Aid Name: _____ Option: _____

Medical Aid Number: _____

Main Member: _____ Pupil Dependant Code: _____

Who do we contact in case of an emergency?

Name of 1st Contact Person: _____

1st Contact Number: _____

Name of 2nd Contact Person: _____

2nd Contact Number: _____

Local Relative or Friend in case parent is not contactable in an emergency:

Surname: _____ Name: _____

Relationship: _____

Telephone: Cell: _____ Home: _____Work_____

Which hospital would you like your child to go to if there is a medical emergency and we are unable to get hold of you (the parent) or guardian?

Name of Hospital: _____

PUPIL MEDICAL HISTORY

HOME DOCTOR'S NAME: _____

DOCTOR'S TELEPHONE NO. (W)_____ (H) _____

A copy of pupil's immunization card must be attached. Please check that ALL recommended vaccines are up-to date. Ask at your local clinic for current recommendations.
Date of last Tetanus Vaccine: _____

Childhood Diseases: Please circle if the pupil has had any of the following:

Mumps, Measles, German measles (Rubella), Chicken pox, other _____

Medical Conditions: Please circle if pupil suffers from or experiences any of the following:

Migraine, Epilepsy, Asthma, Allergic Rhinitis (hay fever), Diabetes, Travel Sickness, Heart Condition, Dizzy Spells, Fits of any type, Nose Bleeds, Insomnia, Bed wetting, Sleep walking, Sleep talking, Colour blindness, Anxiety, Depression, Phobias, Mood Disorder, Autism

Spectrum Disorder e.g. Aspergers, Deafness, Poor eyesight, Physical disability, Bowel disorders, Malaria, Other

Please give details:

_____

_____

Medication: Does the pupil take any regular medication? _____

Name and dosage of medication: _____

_____

_____

If children need to bring medication to school, it must be handed in at the front office. Medication MUST be clearly marked with your child's name, name of medication and reason for medication.

Allergies: Please give details of medication, food, environmental or bites/stings allergies:

_____

_____

How severe is the allergic reaction?

_____

Medical Consent:

I _____, parent/guardian (Father/Mother/Legal Guardian)

of _____ agree that my child may be given over-the-counter medication for common illnesses and conditions as deemed necessary by the school staff, within reason.

In the event that I am not contactable and/or not present at the time of a medical, dental or surgical emergency involving my child, I authorise the headmistress of Southcity Preparatory school, or a member of staff designated by the headmistress, to sign legal consent for said emergency treatment in order to avoid dangerous delays in the treatment of my child.

In the case of a medical emergency, Southcity Christian Schools will ensure that your child is transported to the hospital or doctor if you are unavailable. Please bear in mind that you will be responsible for all hospital, ambulance and doctors accounts.

PLEASE NOTE: It is the responsibility of the parent/guardian to keep all information/telephone numbers fully updated in case of an emergency.

Signature: _____ Date: _____

Witness: _____