# VIVA COLLEGE SCHOOL

*" Great Minds Shape the World "*

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## MEDICAL FORM

The school health policy emphasizes good health for every student which is a fundamental aspect for excellence.

It's important to have current and accurate health information regarding your child's health and medical requirements. All pre- existing health related problems must be reported to the school nurse / doctor together with the supporting diagnosis and prescriptions for their management while the child is at school.

Please complete and submit this form at the time of registration. Should the health requirements or circumstances of your child change, please inform the school nurse /doctor in writing of any changes.

1. Name of student: .....

   Class: ..... Gender: .....

   Date of birth: ..... Blood group: .....

2. Name of parent/guardian: .....

   Telephone contacts, in case of emergency: .....

3. Student's personal doctor (if any): .....

   Telephone contacts: .....

4. Medical insurance: if your child is under any medical insurance, please provide details of medical insurance card, type and number.

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5. **Vaccinations:** Has your child been vaccinated for the following;

| Illness | Yes | No | Date |
|---|---|---|---|
| Chicken pox | | | |
| Yellow fever | | | |
| Measles | | | |
| German measles | | | |
| Typhoid | | | |
| Cholera | | | |
| Hepatitis A | | | |
| Hepatitis B | | | |
| Meningitis | | | |
| Polio(10 year boaster | | | |
| TB | | | |
| Tetanus A and B | | | |
| Bilharzias | | | |
| Whooping cough | | | |
| Mumps | | | |

***If yes, please attach evidence. If No, please make arrangements to have your child vaccinated.***

6. **Medical conditions:**

   (i) Does your child suffer from the following? If yes, please indicate level of severity.

| Condition | Yes | No | Severe | Moderate | Mild |
|---|---|---|---|---|---|
| Asthma | | | | | |
| Diabetes | | | | | |
| Epilepsy | | | | | |
| Heart disease | | | | | |
| Hypertension | | | | | |
| Eczema | | | | | |
| Hearing impairment | | | | | |
| Visual impairment | | | | | |
| Frequent headaches | | | | | |
| Sinusitis | | | | | |
| Others: ..... | | | | | |

If yes, is your child on treatment? **Yes** ☐ **No** ☐

Please give details and evidence if on treatment:

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(ii) Has your child ever been hospitalized or undergone an operation that you feel impacts their current health or well-being?

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7. **Allergies:**

(i) Does your child suffer from any allergies due to:

| Allergy | Yes | No |
|---|---|---|
| Pollen/dust | | |
| Milk/dairy products | | |
| Penicillin | | |
| Fish/sea food | | |
| Chlorine | | |
| Animals | | |
| Bees/bee-stings | | |
| Plants | | |
| Nuts/Nut products | | |
| Other Allergies? ……..... | | |

(ii) Can any of the allergies be potentially fatal?

**Yes** ☐ **No** ☐

If yes, please give details:

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(iii) Please provide any details and treatment of allergies suffered by your child.

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8. Is your child currently receiving or has received in the past, counseling from a psychiatrist, or a counselor?

**Yes** ☐ **No** ☐

If yes, please explain

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9. **Medication:** Does your child take any regular /daily medication?

**Yes** ☐ **No** ☐

If yes, please provide details of medication and dosage:

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10. **Other conditions:** please provide details concerning your child's past or present history of any other medical ,physical, or psychological conditions of which the school should be aware of;

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11. **Consent for treatment/ administration of drugs:**

I.....

parent/guardian of ..... hereby give the school permission to treat, administer any medication/ drugs to my child in case of any medical emergency or otherwise ,should it be considered necessary by the school nurse/ doctor. Where my child is unable to take certain medication, I shall contact the school nurse /doctor, well in advance, to discuss the use of alternative medication.

12. **Declaration:**

We declare that the information provided herein and the accompanying documents are to the best of our knowledge, true and correct.

**Student:** .....

**Sign:** …….....…….**Date :**……

**Parent/ guardian:** .....

**Relationship:**…….....……

**Sign:** …….....…….**Date :**……