HEALTH INFORMATION

Student's Name: _____ Class / Sec: _____ G.R #: _____

Birth Date: _____ Gender: _____ Blood Group: _____

Father's Name: _____ Mother's Name: _____

Pediatrician's Name: _____ Phone: _____

Any known allergies: _____

Asthma (if Yes, medication used to treat attack) _____

Epilepsy (if Yes, medication used to treat attack) _____

Diabetes (if Yes, please indicate how it is handled) _____

Any bleeding tendency: _____

Any significant illness in the past: _____

Any regular medications: _____

Date of last eye test: _____ Date of last hearing test: _____

In case of fever or injury, the school makes every effort to contact a child's parents. If we are not able to contact you, we may need to administer Calpol or Panadol. Please tick the appropriate box and sign.

☐ I give permission for my child to be given Calpol / Panadol for pain or fever when I cannot be reached.

☐ I DO NOT give permission for my child to be given Calpol / Panadol for pain or fever when I cannot be reached.

In case of emergency, If we are not able to contact you, your child will be taken to Ashfaq Memorial Hospital for any necessary medical attention.

Please tick the appropriate box below.

☐ I give permission for my child to receive medical attention.

☐ I DO NOT give permission for my child to receive medical attention.

Emergency Contacts:

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

☐ I give permission for the people as Emergency Contacts to make decisions regarding my child's emergency medical treatment.

☐ I DO NOT give permission for the people listed as Emergency Contacts to make decisions regarding my child's emergency medical treatment.

_____ _____

SIGNATURE DATE