

# AAESS

BSME

## School Health Record

Childs Name	Family Name	Date of Birth	M/F	Class

## Contact Details

Name	Relationship	Mobile No.	Landline No.	Work No.
1.				
2.				
3.				

Medical History (Please tick all that apply)	Medication in Use	Details
<ul style="list-style-type: none"><li>• Diabetes <input type="checkbox"/></li><li>• Epilepsy <input type="checkbox"/></li><li>• Eyesight/Glasses <input type="checkbox"/></li><li>• Hearing <input type="checkbox"/></li><li>• Allergies/Asthma <input type="checkbox"/></li><li>• Immunisation Records <input type="checkbox"/></li><li>• Surgical Operations <input type="checkbox"/></li></ul>		

## **Additional Comments:**

If your child has been identified with a specific health concern then please supply the school with a doctor's report clarifying details/medication that your child will require whilst at school. Medication to be used at school should be in original packaging stating student's name, date of birth and include written instructions for dates, times and dosage with parent's signature. We are happy to assist you with you questions or concerns in this regard.

***PLEASE NOTE THAT A COPY OF STUDENT'S VACCINATION RECORD IS COMPULSORY***

### **Parents' consent to Medication**

In the event your child experiences a minor ailment whilst at school

	YES	NO
Do you give your consent to administer age-appropriate medicine i.e. Brufen, Calpol or equivalent?		
In the event of an emergency may we take your child to hospital (we would notify you as soon as possible)? Name of the Hospital: _____		

Signature of parent: \_\_\_\_\_ Date: \_\_\_\_\_