

Student's Name:

Age:

Blood Group:

Year/Class:

Birth Date:

Gender:

Nationality: Indian / NRI / Others

Address:

Phone (Res.):

Parent (Office):

Parent (Mobile):

*If none of the above is available in an emergency, Please contact:

Name:

Relationship:

Contact No.:

Known Allergies/Medical Conditions:

My Child has had the following: (Please tick)

Allergy to	Name of allergen	Severe Anaphylaxis	Sight / Non Life	None
Foods				
Insects				
Drugs				
Animals				
Grasses, pollen				
Other				
Describe what happens during a reaction?				
In the event of a reaction, what actions are necessary?				
Has hospitalisation occurred because of a reaction (Yes/No):				
Date of hospitalisation:				

Asthma:

Does your child suffer from Asthma? (Yes/No):

If 'Yes' Please indicate how severe your child's Asthma is:

When was your child's last asthma attack?

Required Hospitalisation? (Yes/No): Details of Medication administered:

Mild: Attacks are rare, limited mostly to tightness and wheezing.

Moderate: Occasional attacks which can be self managed using prescribed medication.

Severe: Attacks are regular, severe and have required hospital treatment.

Does your child have Medical Conditions that may require EMERGENCY care?

Please give additional information

Other Medical Information

Yes

No

Frequent nose bleeds

Psychological condition

Hearing impairment

Bed wetting

Contact lens / glasses

Travel sickness

Currently taking long-term medication?

(Yes/No)

If 'Yes', please give additional information

Has your child had a tetanus injection

within the last 10 years (Yes/No):

Dietary Information

Please outline any special dietary requirements of your child and how best they should be catered for on the excursion.

°Vegetarian; °Non-Vegetarian; °Vegan;

I have completed this medical form accurately, truthfully, and to the best of my knowledge as of today's date. I understand that it is my responsibility to inform the school of any new medical condition or change in this information.

I hereby give consent and full authority for the staff or agents of the school to arrange for and consent to any medical treatment or hospitalisation for my child / guardian while s/he is in the care of the school. I further authorise these staff members to enter into and execute, on my behalf, such documents or consents as may be required by Medical Practitioners, Health Care Professionals or Hospitals for such purposes.

You will be required to fill in a short form giving updated medical information since filling in this form during the year.

Signature of Parents/ Guardian:

Name of Parents/ Guardian:

Print name of student:

Relationship to student:

Date:

Please complete all the sections thoroughly, to enable us to update records.

(Parents / Students must send this completed form directly to the School Office Room.)

Student's Name:	Age:	Blood Group:
Birth Date:	Gender:	Date of Physical Exam:
Height:	Weight:	
Blood Pressure:	Pulse:	
Vision:	R:	L:
Normal:	Referred:	
Sports Physical Fitness Form		
Clinical Exam	Normal	Significant History or Abnormal Exam: Explain
1. Skin		
2. Head and neck		
3. Eyes		
4. Ears, Nose and Mouth		
5. Cardiovascular		
6. Respiratory (asthma, other)		
7. Abdomen		
8. Musculoskeletal (scoliosis check)		
9. Neurological		
10. Emotional/mental health status		
11. Nutritional status		
12. Developmental status		
13. Surgery or serious illness		
14. Other		
Summary of current health condition, medications and therapies:		

I hereby certify that this student was examined by me with particular to those systems affected by strenuous physical activities. At this time, no physical condition has been detected which would reasonably be anticipated to render them physically unfit to engage in the following sports or activities; softball, basketball, netball, football, throw ball, kickball, tennis, cricket and track events, Skating or other outdoor pursuits.

Name of the Physician & Stamp:

Signature:

Date: