



MEDICAL CONSENT & EMERGENCY CONTACT FORM

STUDENT NAME: _____ **Grade:** _____
(Last) (First) (Middle)

Student Preferred or Nicked Name: _____ Male Female

Date of Birth: _____ Height: _____ Weight: _____
(Day) (Month) (Year)

Nationality: _____ ID/Passport: _____ Religion (if any): _____

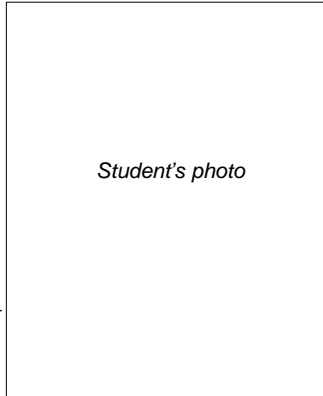
Blood Type(if known): _____

Home Address: _____ Town/City _____ Postal Code: _____

Mother's Name: _____ Phone Number: _____

Father's Name: _____ Phone Number: _____

Sibling(s) Name: _____



EMERGENCY CONTACTS

Name: _____ Relationship: _____ Phone No.1: _____ Phone No.2: _____

Name: _____ Relationship: _____ Phone No.1: _____ Phone No.2: _____

MEDICAL INSURANCE

Does your child have medical insurance? Yes No Medical Insurance Provider: _____
Policy Number: _____ Insurance Emergency Call Center Number: _____

*If you child has no insurance, please tick the box sign below:

I acknowledge that my child has no medical insurance policy and that I will be responsible for any fees incurred due to personal loss or injury.

Sign: _____

Please provide name of clinic/hospital you would prefer your child to be taken to in case of emergency:

MEDICAL INFORMATION *Please indicate with a tick (✓) if your child suffers any of the following:*

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Seizures of any type | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Travel Sickness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Asthma | <input type="checkbox"/> Recent breaks or sprains |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Allergies | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Hearing Difficulties | <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Visual Problem |
| <input type="checkbox"/> Urinary Infection | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Orthopedic Condition |

Others (Please specify): _____

Please give further details of ANY boxes that you have ticked, or any other relevant information, including dietary considerations. Please write N/A if there is nothing to add. _____



MEDICATION

I don't allow any medication to be given to my child.

I allow the following medications to be given to my child in case of sickness or emergency.

*Tick (✓) the following medication you allow to be administered by the school nurse.

Generic Name: Paracetamol (Antipyretic, Analgesic) • For fever and pain		Phenylephrine HCL + Paracetamol • For cold and flu	
Tylenol Suspension		Panadol Tablet	
Biogesic Suspension for children			
Panadol Tablet			
Generic Name: Ibuprofen (Anti-inflammatory, Antipyretic, Analgesic) • For fever, pain and inflammation		Salbutamol Bromhexine (Mucolytic) • For cough	
Mylan Tablet		Ascoril syrup	
Upro Tablet		Aluminum hydroxide and magnesium hydroxide (antacid) • For gastritis • Dyspepsia • Upset stomach • Acid indigestion	
Upro Suspension for children		Maalox	
Generic Name: Citirizine (Antihistamine) • For allergic reaction • Allergic rhinitis		Domperidone (Antiemetic) • For Nausea and Vomiting	
Zyrtec Tablet		Motilium	
Allergyl Syrup		Diosmectite (Antidiarrheal, Intestinal Antiinflammatory) • For painful symptoms of diarrhea and other gastrointestinal disorders	
Promethazine • For allergic reaction		Smecta	
Phenergan Syrup			
Phenylephrine HCL + Paracetamol+ Dextro methorphan+Cetirizine • For Cough, cold, flu and fever			
Sinex Forte Tablet			
Dimetapp syrup for children			

Sign:



IMMUNISATIONS

*Please provide us with the vaccination record of your child or fill out the following.

Tetanus: _____ Date: _____ Booster: _____

Rabies: _____ Date: _____ Booster: _____

Other shot(s) according to local health requirement:

DPT (Diphtheria/Pertussis/Teatanus) Date: _____ Booster: _____

OPV (Oral Polio Vaccine) Date: _____ Booster: _____

BCG (TB Vaccine) Date: _____ Booster: _____

TB Skin Test Date: _____ Booster: _____

Other Vaccinations:

1. _____ Date: _____ Booster: _____

2. _____ Date: _____ Booster: _____

SWIMMING LEVEL

Non-Swimmer Beginner Intermediate Advanced

COMMENTS/CONCERNS:

I, _____, legal guardian of _____ certify that that the above information is correct and current as of today.

Sign over printed name:

Date: _____