THE BRITISH COLLEGE OF BRAZIL
A NORD ANGLIA EDUCATION SCHOOL

Medical Record

Student: _____.
Date of Birth: _____ Country of birth: _____

Parent/Guardian Information:

1. Name: _____
   Phone Number: _____ Relationship to child: _____
   E-mail: _____
   Best way to contact: _____
2. Name: _____
   Phone Number: _____ Relationship to child: _____
   E-mail: _____
   Best way to contact: _____

Emergency contacts (If parent/guardian cannot be reached):

1. Name: _____.
   Phone Number: _____ Relationship to child: _____.
2. Name: _____.
   Phone Number: _____ Relationship to child: _____.

Medication:

In case of pain or fever, can medicine be given to your child? [ ] Yes [ ] No. Wich one?
_____.

Additional Information:

Does your child have any of the following conditions?

☐ Asthma	☐ Frequent sore throat/cold	☐ Headache	☐ Diabetes
☐ Epilepsy/Seizures	☐ Earache	☐ Nosebleed	☐ Other

Is there any specific information about your child's health we should be aware of? (Food restriction for example due to religion; previous surgery/diseases)

_____

_____.

Blood type and Rh factor: _____.

Immunisation status: To be completed by health care provider. The month/day/year for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5	DOSE 6
DTP or DTaP						
Polio (OPV or IPV)						
Hib Haemophilus influenza type b						
Hepatitis B						
MMR (Measles, Mumps and Rubella)						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
Influenza						
HPV						
Yellow Fever						
Other: Specify Immunization Administered/Dates						

Health Insurance information:

Does your child have health insurance?) [ ] Yes [ ] No; If yes, please specify:_____.

Please tick the option you prefer in case of emergency:

☐ My child must only be taken to the hospital mentioned. Wich one? _____.

☐ My child can be taken to the nearest hospital

☐ My child must be taken to the hospital using the health insurance's ambulance

Consent for Emergency Medical Treatment

I understand that information given above will be shared with appropriate school staff to provide for the health and safety of my child. In the event of an accident or illness, and where it is impracticable to communicate with me, I give permission for school staff to seek medical care as deemed necessary. I hereby confirm I will be responsible for any and all expenses resulting from medical care.

Parent Name (please print): _____.

Signature: _____ Date: _____.