Christ The King Nursery and Primary School Kiyuni

MEDICAL & PHYSICAL INFORMATION

PLEASE WRITE IN BLOCK LETTERS

Information on Student

Name of Student – First_____ Surname _____ Nationality _____

Date of Birth (dd/mm/yy)_____ Gender M __ F ___ Number of Children in Family_____

Name of Parents or Legal Guardians _____

Physical Home Address of Student _____

Home Telephone _____ Mobile Telephone _____

Alternative Telephone Contact in case parents cannot be contacted _____

Name and Relationship to Student_____

Name of Physician in Kampala _____ Telephone _____

Health Information

Allergies - Food /Medicine/Insects and Others _____Chronic, Recurring Health Conditions:

Asthma Diabetes Epilepsy Sickle Cell Migraines Hepatitis

Others (Please State): _____

Other Difficulties: ADHD Visual Problems Hearing Problems

Others (Please State): _____

Has your child had any operations or hospitalization? Yes No

If yes, please state: _____

Does your child visit a dentist at least once a year? Yes No

Does your child routinely take medicines? Yes No

If Yes, please state: _____

Does your child require emergency medication which may need to be administered in school such as Epi Pen, Asthma inhaler, allergy medication, etc.? Yes No

If Yes, please state: _____

PLEASE NOTE: Such personal medication must be provided by parents, labelled with the student's name, administration instructions and brought to the school Health Clinic on admission to ISU.

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Does your child have any physical problems which would prevent him/her from participating in Physical Education classes/after-school activities / field trips? Yes No

If Yes, please state: _____

Consent to Treatment / Transfer

I agree that ISU Health Clinic nurses will, if unable to contact parents, give any treatment they deem to be necessary.

I agree that in an emergency, if my child requires urgent medical treatment and school nurses are unable to contact parents, my child will be transferred by ambulance to 'The Surgery'. I will be liable for costs associated with this ambulance transfer and subsequent treatment.

Signature of Parent_____ Date _____

For Official Use - Vaccination Record

IMMUNIZATION	DATES AND DOSES GIVEN				
POLIOMYELITIS	1	2	3	4	5
DIPHTERIA, TETANUS, PERTUSSIS	1	2	3	4	5
DIPHTERIA, TETANUS	1	2	3	4	5
TETANUS: SPECIFY DATE WHEN LAST GIVEN -					
HAEMOPHILUS INFLUENZA	1	2	3	4	
MEASLES, MUMPS, RUBELLA	1	2			
HEPATITIS B	1	2	3		
HEPATITIS A	1	2			
MENINGITIS (C OR A & C)	1				
TUBERCULOSIS (BCG)					
YELLOW FEVER					
RABIES					
OTHER					

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Physical Examination Report: To be Completed by a Medical Practitioner Before Admission

Height _____Weight_____ BP _____ Pulse _____

Nutritional Status _____ BMI _____

Vision Screening - Distance Vision – L _____R _____Reading – L _____ R_____

Colour Vision _____ Hearing Screening _____

Systems Examination:

_____

_____

Summary of Abnormal Findings:

_____

Recommended Treatment or Referrals:

_____

Is there any medical condition that would prevent this student from safely participating in any physical activities or field trips? Yes ☐ No ☐

If yes, please state condition and activities to exclude:

_____

_____

Name of Physician _____ Telephone _____

Physical Address of Physician _____

Physician's Signature _____ Date _____