

## Medical Records Form

### Student Medical Records

Name of child \_\_\_\_\_  
Surname First Name Other Names

a) Does your child have any health problems, allergies that we should be aware of?

Yes  No  (If yes give details)

\_\_\_\_\_

\_\_\_\_\_

b) Is there any other information that we should know about? Yes  No

If yes give details

\_\_\_\_\_

\_\_\_\_\_

### Current Immunisation Records

	Yes	No	Date
DPT (Diphtheria, Pertussis, Tetanus)			
Hepatitis B			
Polio			
MMR (Measles, Mumps, Rubella)			
Whooping cough			
Chicken Pox			
Tuberculosis			

### Emergency Contact

Name \_\_\_\_\_

Tel. No. \_\_\_\_\_ Mobil no. \_\_\_\_\_

Medical Insurance company \_\_\_\_\_

Place, Date \_\_\_\_\_ Signature \_\_\_\_\_