MEDICAL ATTENTION FORM

HEALTH ASSESSMENT (To be completed by parent/guardian)

Surname (s)

First Names

◉ *Male* ○ *Female* Date of Birth

Nationality DNI/NIE/Passport

Family Doctor Social Security Number

Private Health Insurance Cover:

Company Policy nº Tel.

EMERGENCY CONTACT

1 Name

Telephone Work/Home Mobile Phone

Relationship to Student

2 Name

Telephone Work/Home Mobile Phone

Relationship to Student

ASSESMENT OF STUDENT HEALTH

To the best of your knowledge, has your child had any problem with the following? Please check

	YES	NO	Comments
Infectious Diseases (ChickenPox, mumps, etc.)	◉	○	
Seasonal allergies or Hay fever	◉	○	
Allergies (Food, insects, drugs, latex...)	◉	○	
Psychological problems	◉	○	
Birth Defects	◉	○	
Cerebral Palsy	◉	○	
Dental	◉	○	
Diabetes	◉	○	
Ear problem or Deafness	◉	○	
Eye or Vision problems	◉	○	

	YES	NO	Comments
Head or Spinal Injury	○	○	
Heart Problems	○	○	
Hospitalization/ surgery	○	○	
Learning difficulties	○	○	
Limits on Physical Activity	○	○	
Meningitis	○	○	
Prematurity	○	○	
Problem with Bladder	○	○	
Problem with Bowels	○	○	
Seizures	○	○	
Speech Problems	○	○	
Asthma or Breathing Problems	○	○	
Others	○	○	

MEDICAL HISTORY

Do you have any current concerns regarding your child's health?

If your child is unwell at home, what is your preferred treatment? (e.g. Paracetamol / Ibuprofen etc.)

Does your child have a special diet or medication?

UPON ADMISSION TO THE SCHOOL, PLEASE ENCLOSE YOUR CHILD'S OFFICIAL IMMUNISATION RECORD FOR REVIEW BY THE SCHOOL NURSE.

Is your child up to date with their immunisation program?

Which countries immunisation program is your child following?

Dates of any immunisations SINCE admission to school

Immunisation ..... Date .....

Immunisation ..... Date .....

Immunisation ..... Date .....

Immunisation ..... Date .....

PARENT/GUARDIAN'S DECLARATION

I, being the Responsible Person of the above named pupil, declare that all information is accurate to my knowledge.
I will inform the school of any changes in my child's health. I authorise the school nurse to administer treatment for minor general health problems on the school premises.
I authorise the school to administer any necessary emergency medical treatment or preferred medication to the pupil, through qualified personnel, acting on the directions of the school.

Signature of responsible person

Full Name .....

Date .....