HEBRON SCHOOL

PREADMISSION MEDICAL FORM FOR STUDENTS

Note: PLEASE USE **BLOCK** LETTER TO COMPLETE THIS FORM

All questions MUST be answered honestly. We reserve the right to refuse admission if this form is not completed. Moreover, **if a known medical condition is not disclosed and a student is admitted, we reserve the right to ask for the student to be withdrawn even after admission**. Please return with admission form.

SURNAME:…………………………FIRST NAMES: …………………………………...

DATE OF BIRTH: ……………………… SEX: MALE / FEMALE

PARENT/ GUARDIAN: NAME: …………………………………………………………

ADDRESS: …………………………………………………….

……………………………………………………..

……………………………………………………..

EMERGENCY TEL. NO.:

EMAIL ADDRESS: ……………………………………………………………………

Please ensure that you inform the school of any changes in address/telephone nos./ email.

CHILD'S PRESENT HEALTH:

1. Is you child receiving medical attention at present? Yes No

If yes, for what reason?...

…………………………………………………………………………………………

…………………………………………………………………………………………

2. Does she/he take regular medications? Yes No Details below

CONDITION	MEDICATION	DOSAGE	WHEN TAKEN

3. Does she/he take medications in particular circumstances? Yes No

CONDITION	MEDICATION	DOSAGE	WHEN TAKEN

4. Does she/ he have any medical condition not requiring medication?

If yes, please comment ……………………………………………………………………..

…………………………………………………………………………………………

5. Child's blood group and rhesus factor: ……………………………………………….

6. Does your child have allergies? (include hay fever, etc.)
Please provide details and reactions of any allergies:……………………………………

…………………………………………………………………………………………

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7. CHILD'S MEDICAL HISTORY

Has your child ever had consultation or treatment from the following specialists

SPECIALIST	WHEN	REASON	TREATMENT	FOLLOW UP
ORTHOPAEDIC				
SPEECH THERAPIST				
PHYSIOTHERAPIST				
PSYCHIATRIST				

8. **HEARING**: Has your child had any of the following?

PROBLEM	RESPONSE	DETAILS
REPEATED EAR INFECTIONS	YES NO	
DISCHARGING EARS	YES NO	
EAR OPERATION	YES NO	

Has your child had a hearing test? Yes/ No – When? ……………………………………

Was any hearing loss detected? ……………………………………………………………

Treatment : …………………………………………………………………………………

9. VISION: Has your child had any of the following?

PROBLEM	RESPONSE	DETAILS
POOR SIGHT	YES NO	
SQUINT	YES NO	
EYE INJURY	YES NO	
EYE OPERATION	YES NO	

Has your child had an eyesight test? Yes / No

Date of last eyesight test …………………………. Date of next test…………………….

Does your child require glasses? Yes / No

When are the glasses to be worn? ………………………………………………………….

Note: It is requested that a spare pair of glasses and their prescription be sent with your child.

10. PHYSICAL DISABILITY

If you child has a physical disability, please give details:………………………………….

……………………………………………………………………………………………

……………………………………………………………………………………………

Would your child require special assistance at School?

Details: ……………………………………………………………………………..

11. Has your child had any: (Please give details)

Major Accidents:……………………………………………………………………….

……………………………………………………………………………………………

……………………………………………………………………………………………

Operations, including dates and any reaction to general anaesthetic: ……………………..

……………………………………………………………………………………………

……………………………………………………………………………………………

12. Has your child shown or been treated for any of the following problems in the last twelve months?

AGRESSION	YES	NO	INSOMNIA	YES	NO
DEPRESSION	YES	NO	BED WETTING	YES	NO
TEMPER TAMTRUMS	YES	NO	NIGHT MARES	YES	NO
EATING DISORDERS	YES	NO	SLEEP WALKING	YES	NO
RECENT WEIGHT GAIN/ LOSS	YES	NO	MOTION SICKNESS	YES	NO

If yes to any of the above, please give details:……………………………………………..

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13. Has your child ever suffered any of the following?

DISEASE		**DATE**	**TREATMENT**
CHICKEN POX	YES / NO		
MEASLES	YES / NO		
MUMPS	YES / NO		
WHOOPING COUGH	YES / NO		
POLIO	YES / NO		
HEPATITIS A	YES / NO		
HEPATITIS B	YES / NO		
MALARIA	YES / NO		
GLANDULAR FEVER	YES / NO		
MENINGITIS	YES / NO		
ENCEPHALITIS	YES / NO		
TUBERCULOSIS	YES / NO		
BLADDER OR KIDNEY INFECTION	YES / NO		
ANAEMIA	YES / NO		

14. Does your child have any of the following?

CONDITION		DATE WHEN FIRST APPEARED	TREATMENT
EPISEPSY	YES / NO		
DIABETES	YES / NO		
ECZEMA	YES / NO		
HEART CONDITION	YES / NO		
THYROID DISORDER	YES / NO		
ASTHMA	YES / NO		
HAEMOPHILIA	YES / NO		
HERNIA	YES / NO		
HAEMORHOIDS	YES / NO		
RECURRENT HEADACHE	YES / NO		
ME/CHRONIC FATIQUE SYNDROME	YES / NO		

Please record here any other condition your child has / does suffer from, including

treatment: ……………………………………………………………………………………..

……………………………………………………………………………………………...

……………………………………………………………………………………………...

………………………………………………………………………………………………

15. FAMILY HISTORY

Is there a family history of any of the following?

CONDITION	DETAILS
ALLERGIES	
ASTHMA	
DIABETES	
EPILEPSY	
HIGH/LOW – BLOOD PRESSURE	
HEART CONDITIONS	
MENTAL ILLNESS	

Please record here any other conditions in you family you think are relevant to your child's health: …………………………………………………………………………………

…………………………………………………………………………………………………

16. Has your daughter commenced her periods YES NO
If yes, are her periods regular YES NO
Does she suffer from pain or any other problems before or during her periods?............

…………………………………………………………………………………………

…………………………………………………………………………………………

What does she find help relieve the above problems? ………………………………..……

……………………………………………………………………………………………..….

Has she ever had abnormal vaginal discharge? …………………………………………....

……………………………………………………………………………..……………

SIGNATURE: ………………………………………………………………………….

RELATIONSHIP TO THE CHILD:…………………………. **DATE**:………………..