



HEALTH INFORMATION SCHEDULE

Please pay specific attention to any clause in **red or bold!** These clauses either require an **acknowledgement** by you, you are taking on any **risk or liability** or **limiting the risk or liability** of the School or you **are indemnifying** the School. Please **read this Health Information Schedule carefully** and ask if you have any questions!

CHILD'S DETAILS:

| | | | | | | | | | | |
|-------------------------|---|---|---|---|---|---|---|---|------|--|
| Full Names and Surname: | | | | | | | | | | |
| Date of Birth: | D | D | M | M | Y | Y | Y | Y | Age: | |

PARENTS DETAILS:

| | |
|----------------------------|--|
| Mother's Name and Surname: | |
| Father's Name and Surname: | |

DOCTOR'S DETAILS:

| | |
|-------------------|--|
| Name and Surname: | |
| Practise Name: | |
| Contact Number: | |

MEDICAL AID *(If applicable):*

| | |
|--------------------|--|
| Main Member: | |
| Medical Aid Name: | |
| Plan: | |
| Membership Number: | |

IMMUNISATION *(If applicable):*

| | |
|---------------------------------|-----------------------------|
| Vaccination: | Date of Vaccination: |
| Whooping Cough, Diphtheria: | |
| Tetanus (3 in 1 or DWT): | |
| Polio: | |
| BCG Vaccination (Tuberculosis): | |
| Measles, Mumps, Rubella: | |

MEDICAL HISTORY:

Has your Child suffered from the following?

| | YES | NO | | YES | NO |
|-----------------|-----|----|----------------|-----|----|
| Measles | | | Diphtheria | | |
| Chickenpox | | | Mumps | | |
| Rheumatic Fever | | | Whooping Cough | | |
| Scarlet Fever | | | Asthma | | |



Has your Child undergone any operations? *If yes, please specify:*

Any other medical problems? *If yes, please specify:*

Does your Child suffer from any allergies? *If yes, please specify:*

Is your Child a vegetarian or vegan? *If yes, please specify:*

Any other food restrictions? *If yes, please specify:*

MEDICAL EMERGENCY SITUATION

I hereby consent and give permission to the School to:

1. Seek medical attention for my child **and transport my Child** in the case of an emergency.
2. Attend to such injury *in loco parentis*.
3. Consent to any medical treatment for my child should such consent be required for medical reasons on an urgent basis and:
 - a. *should it not be possible for the parents and/or legal guardians to be contacted timeously; and/or*
 - b. *in the case where the parents and/or legal guardians cannot be reached.*
4. I agree that all expenses incurred by the School shall be for my account and I shall reimburse the School in full.

Signature of Guardian: _____

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|