HEALTH CARD

Student Name **Surname** **Ref No.**

Grade/Div.:_____Roll No.:_____Date of Birth :_____

Height :_____Weight :_____Blood Group : _____

Does your child have any

1. Health concerns : _____

2.Allergies : _____

3. Asthma : _____

4. Diabetes : _____ Seizures_____

5. Head injuries :_____ Dental _____

6. Orthopedic : _____ Others_____

7. Restrictions on Physical Activity :_____

I certify that I have checked the patient above.

Restrictions (If any) _____

Name of Doctor : _____

Clinic Address : _____

Tel No.: _____

Doctor's Sign/Seal

The above information is current & correct. I understand it is my responsibility to notify the school of existing/new health concerns & my contact numbers are updated.

In any emergency, I permit the school to take my child to the nearest medical facility, and if needed, **Yes / No**

I permit the school to administer medication in my absence as follows

Antacids/Digene;
Paracetamol/Crocin,
Anti-histamine/Anti-allergic:

Yes / No

Signatures

Father: _____ Cell: _____

Mother:_____Cell: _____

Guardian:_____Cell: _____