Student Health Form.

PHOTO

Student's personal and contact details: Student Ref nº:

Surname _____

First name _____

Date of birth: _____ (dd-mm-yyyy)

Blood group _____

Father's /guardian's mobile nº _____ business tel.Nº _____

Mother's /guardian's mobile nº _____ business tel.Nº _____

Please confirm details of one other person who may act in loco parentis should the school be unable to reach you in an emergency.

Name: _____

Tel nº: _____

Medical treatment in case of emergency:

In the event of an accident and the school being unable to contact a parent, do you give consent for a representative of the school to give permission for medical treatment? YES ☐ NO ☐

Health insurance membership: _____

Name of family doctor: _____ tel nº: _____

Vaccinations

Is your child following a vaccination program? YES ☐ NO ☐ _____

When did your child have his/her last Diphtheria and Tetanus vaccination? _____ (dd-mm-yyyy)

Do you want the nurse to keep you updated about coming vaccinations of your child? YES ☐

If Yes, Please submit a copy of your child's vaccination booklet.

Please note that it is the responsibility of the parent to ensure that all vaccinations are up to date, according to the Portuguese national vaccination program

Medical information

Has your child ever had any of the following problems? (Only mark if YES)

Condition	**YES**		**YES**		**YES**		**YES**
Allergies; seasonal/hay fever/food[1]	☐	Behavioural Problems	☐	Chronic ear infections	☐	add/adhd	☐
Allergy; life threatening/anaphylaxis[2]	☐	Developmental Problems	☐	Frequent Headaches	☐	asthma[3]	☐
anaemia or other blood problems	☐	Eczema/Chronic Skin Condition	☐	Heart disease	☐	Cancer	☐
Blood Pressure Problems (High/Low)	☐	Frequent Stomach aches	☐	Kidney disease	☐	Depression	☐
Chronic Diarrhoea or Constipation	☐	Hearing/Ear Problems	☐	Learning problems	☐	Diabetes[4]	☐
Emotional/Psychological Problems	☐	Seizure Disorder/Epilepsy/Tics[5]	☐	Sleep Problems	☐	Other:	☐
Eye problems/Glasses/Contacts	☐	Tooth/Dental Problems	☐	Speech Problems	☐		

[1] Please fill in the Asthma and Allergy Care Plan.
[2] Please fill in the Anaphylaxis/Severe Allergies Care Plan.
[3] Please fill in the Asthma and Allergy Care Plan.
[4] Please fill in the Diabetes Care Plan
[5] Please fill in the Seizure Disorder Care Plan

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CURRENT allergies: (include food, medications, environmental, seasonal, etc.):

CURRENT health problems or conditions. Please Specify in 2nd column.

Please list any medications (prescribed or over-the-counter) your child takes at home on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches):

Condition:	**Name Medication:**	**Daily Dose:**

Does your child see a specialist?
If yes, please list condition, doctor's name, and phone number: YES ☐ NO ☐

Condition:

Name doctor: Phone nº

Illnessess in family

	Mother	Father	Siblings	Other
Allergies	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Seizure disorders	☐	☐	☐	☐
TBC	☐	☐	☐	☐
Other chronic illn.	☐	☐	☐	☐
Visual impairment	☐	☐	☐	☐
Hearing loss	☐	☐	☐	☐

Childhood diseases

pertussis	☐
measles	☐
Mumps	☐
Chicken pox	☐
Rubella	☐
Pregnancy without incidents	☐

Other diseases/problems:

Any student who is required to take medication[6] prescribed for him/her by a doctor, may be assisted by the school nurse or other designated school personnel, providing the school receives the **Permission to give Prescription Medication at school** form. This form needs to be signed at the start of **every school year** or if the student needs new medication.

If your child requires medication on an intermittent basis (such as for asthma), this medication should be left with the school nurse, together with the **Permission to give Prescription Medication at school** form, and it will be stored in a locked cabinet, labelled with the child's name and dosage.

If your child is allowed to take his/her own medication at school **the Contract for students carrying medication at school** needs to be signed by both student and parents/guardians. This form needs to be signed at the start of **every school year**.

Please indicate whether you **give permission** for the school nurse and designated personnel to administer over-the-counter medication like pain relievers, anti-inflammatory medications and anti-histamines, throughout the school year. YES ☐ NO ☐

Please indicate whether you **give permission** to share this information with the school health team. YES ☐ NO ☐

Name of parent / guardian:

Date:

[6] The medication policy is attached for your reference.