

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	Condition	YES	Condition	YES	Condition	YES
Allergies; seasonal/hay fever/food <sup>1</sup>	<input type="checkbox"/>	Behavioural Problems	<input type="checkbox"/>	Chronic ear infections	<input type="checkbox"/>	add/adhd	<input type="checkbox"/>
Allergy; life threatening/anaphylaxis <sup>2</sup>		Developmental Problems		Frequent Headaches		asthma <sup>3</sup>	
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 <sup>4</sup>	
Emotional/Psychological Problems		Seizure Disorder/Epilepsy/Tics <sup>5</sup>		Sleep Problems		Other:	
Eye problems/Glasses/Contacts		Tooth/Dental Problems		Speech Problems			

<sup>1</sup> Please fill in the Asthma and Allergy Care Plan.

<sup>2</sup> Please fill in the Anaphylaxis/Severe Allergies Care Plan.

<sup>3</sup> Please fill in the Asthma and Allergy Care Plan.

<sup>4</sup> Please fill in the Diabetes Care Plan

<sup>5</sup> Please fill in the Seizure Disorder Care Plan

# Student Health Form.

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


**CURRENT** health problems or conditions. Please Specify in 2<sup>nd</sup> 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 n° \_\_\_\_\_

Illnesses in family	Mother	Father	Siblings	Other
Allergies			<input type="checkbox"/>	
Diabetes				
Seizure disorders				
TBC				
Other chronic illn.				
Visual impairment				
Hearing loss				

Childhood diseases
pertussis
measles
Mumps
Chicken pox
Rubella
Pregnancy without incidents <input type="checkbox"/>

Other diseases/problems:

Any student who is required to take medication<sup>6</sup> 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: \_\_\_\_\_

<sup>6</sup> The medication policy is attached for your reference.