

Student Medical Information Form

St Paul Rongo Mixed Secondary School

Confidential Medical Form

This information is kept strictly confidential and is used to ensure the safety and well-being of your child while at school.

SECTION 1: STUDENT INFORMATION

Full Name of Student: _____

Date of Birth: _____

Gender: ☐ Male ☐ Female ☐ Other

Class/Grade: _____

Admission Number: _____

SECTION 2: PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian Name(s): _____

Relationship to Student: _____

Phone Number(s): _____

Alternative Contact (Name & Phone): _____

Home Address:

SECTION 3: MEDICAL HISTORY

1. Does your child have any allergies (e.g., food, medicine, insects)? ☐ Yes ☐ No

If yes, please list: _____

2. Does your child have any chronic medical conditions? (e.g., asthma, epilepsy, diabetes) ☐
Yes ☐ No

If yes, please specify: _____

3. Is your child currently taking any medication? ☐ Yes ☐ No

If yes, please list medication and dosage: _____

4. Has your child been hospitalized in the past year? ☐Yes ☐No

If yes, please explain: _____

SECTION 4: IMMUNIZATION RECORD

Vaccine	Date Received
BCG	_____
Polio	_____
DPT (Diphtheria, etc.)	_____
Measles/Mumps/Rubella	_____
Hepatitis B	_____
Others (specify)	_____

SECTION 5: EMERGENCY MEDICAL CONSENT

In the event of an emergency, I give permission for my child to receive medical treatment by a licensed physician or first responder.

Parent/Guardian Signature: _____

Date: _____

SECTION 6: SCHOOL NURSE/OFFICE USE ONLY

Notes: _____

Follow-up Required: ☐Yes ☐No

Date Reviewed: _____

Staff Signature: _____