

# GRANTLEIGH



## DAY SCHOLAR MEDICAL FORM

STUDENT'S FULL NAME: \_\_\_\_\_

MEDICAL AID NAME & OPTION: \_\_\_\_\_

MEDICAL AID Nr: \_\_\_\_\_

DOCTOR'S NAME & TEL Nr: \_\_\_\_\_

NAME & CONTACT DETAILS:

MOTHER: \_\_\_\_\_

FATHER: \_\_\_\_\_

GUARDIAN: \_\_\_\_\_

ALTERNATIVE CONTACT NAME AND CONTACT NUMBER IN CASE OF EMERGENCY WHERE PARTENTS/GUARDIAN CANNOT BE CONTACTED:

\_\_\_\_\_  
\_\_\_\_\_

DOES THE STUDENT SUFFER FROM ANY ALLERGIES? Yes / No \_\_\_\_\_

IF YES, PLEASE GIVE DETAILS OF ALLERGY AND MEDICATION:

\_\_\_\_\_

DOES THE STUDENT HAVE ANY CHRONIC MEDICAL CONDITIONS?

Yes / No \_\_\_\_\_ IF YES, PLEASE GIVE DETAILS

\_\_\_\_\_

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DOES THE STUDENT TAKE ANY CHRONIC MEDICATION? Yes / No \_\_\_\_\_

IF YES, PLEASE GIVE DETAILS, THIS INCLUDES MEDICATION FOR ADD/ADHD

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PREVIOUS MEDICAL HISTORY OR ILLNESS:

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PREVIOUS OPERATIONS OR SURGICAL PROCEDURES: Yes / No \_\_\_\_\_

IF YES, PLEASE SPECIFY YEAR/DATE

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DOES YOUR CHILD SUFFER FROM?

POOR HEARING?

POOR SPEECH?

POOR VISION?

WEAR GLASSES?

IS THERE ANY REASON WHY YOUR CHILD SHOULD NOT PARTICIPATE IN SPORT OR PHYSICAL EDUCATION? Yes / No \_\_\_\_\_

IF YES, PLEASE GIVE DETAILS

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ARE ALL CHILDHOOD IMMUNISATIONS UP TO DATE?

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PLEASE ATTACH COPY OF IMMUNISATION CARD.

**PLEASE NOTE THAT IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO SUPPLY THE SCHOOL WITH ALL NECESSARY INFORMATION REGARDING THE CHILD'S HEALTH.**

**WHERE NECESSARY PLEASE ENSURE THAT MEDIC ALERT BRACELETS ARE WORN.**

Sign (Parent/Guardian) \_\_\_\_\_ Dated: \_\_\_\_\_

