BOARDER MEDICAL FORM

MEDICAL SERVICES (Hospitals, X-Ray, Doctors, Pharmacies, Physiotherapists etc.)

REQUIRE THE INFORMATION LISTED BELOW IN ORDER TO PROVIDE TREATMENT

IF YOU FAIL TO SUPPLY US WITH A COPY OF YOUR

MEDICAL AID CARD AND MAIN MEMBER'S ID

EMERGENCY TREATMENT OF YOUR CHILD COULD BE DELAYED

The attached forms must be completed in full and returned to the school ASAP.

Completed forms may be returned by any of the following options:

- Hand in at Reception in an envelope marked for the attention of Sanatorium
- Fax to: 035-5801457
- Email to: kerry.m@curro.co.za

PARENTS WHO HAVE MEDICAL AID:

- Fill in the details of the main medical aid member
- Fill in the details of your medical aid
- Attach a copy of BOTH SIDES of your medical aid card
- Attach a copy of the main member's ID

PARENTS WHO DO NOT HAVE MEDICAL AID

- Fill in the details of the person responsible for paying the medical accounts
- Attach a copy of this person's ID

Please ensure you inform the Sanatorium Sister of any changes to your medical aid.

You will always be informed prior to an appointment, should your child need to see a doctor or dentist, unless it is an emergency, please note we will always endeavour to contact you asap.

BOARDERS' MEDICAL INFORMAION

CHILD'S SURNAME: ______________________________ **FIRST NAMES:** ________________________________

DATE OF BIRTH: ___________________________________ **CHILD'S ID:** ________________________________

DETAILS OF PERSON LIABLE FOR MEDICAL, DENTAL AND PHARMACY ACCOUNT

IN THE CASE OF MEDICAL AID, DETAILS MUST BE OF MAIN MEMBER

SURNAME: ____

FIRST NAMES: ____

POSTAL ADDRESS: ____

____ **CODE:** ________________

RESIDENTIAL ADDRESS: ____

____ **CODE:** ________________

ID: ____

OCCUPATION: ____

NAME AND ADDRESS OF PLACE OF EMPLOYMENT: ____

____ **CODE:** ________________

PHONE NO: WORK: ____________________________________ **HOME:** __________________________________

CELL: ____________________________________ **EMAIL:** __________________________________

MEDICAL AID NAME: ______________________________ **MEDICAL AID NO:** ______________________

MEDICAL AID OPTION: ________________________________

DEPENDANT CODES: MAIN MEMBER ___________________________ **CHILD** ___________________________

PLEASE ATTACH A COPY OF BOTH SIDES OF MEDICAL AID CARD
AND FIRST PAGE OF ID BOOK (MAIN MEMBER).

THE SCHOOL'S DOCTORS/DENTISTS WILL BE APPOINTED BY THE SANATORIUM SISTER AFTER CONSULTATION WITH THE PARENTS/GUARDIANS.

FOR OFFICE USE ONLY

BOARDERS' MEDICAL INFORMAION

OFFICE USE ONLY

DOCTOR (RICHARDS BAY/EMPANGENI): ____________________

DENTIST (RICHARDS BAY/EMPANGENI: ____________________

CHURCH AFFILIATION: ____________________

CONTACT TELEPHONE NUMBERS OF OTHER PARENT:

SURNAME: ____________________ TITLE: (MR/MRS) ____________________

FIRST NAME: ____________________ HOME TEL: ____________________

WORK TEL: ____________________ CELL: ____________________

E-mail address: ____________________

EMERGENCY DETAILS

IN THE CASE OF AN EMERGENCY
AND THE SCHOOL IS UNABLE TO CONTACT EITHER THE MOTHER OR FATHER
THE FOLLOWING PERSON SHOULD BE CONTACTED:

NAME: ______________________________ RELATIONSHIP: ______________________________

CONTACT TELEPHONE NUMBERS: (W) ______________________________ CODE: ____________

(H) ______________________________ CODE: ____________

CELL: ____

1. Has your child had any of the following ailments?

Measles ______________________________

Mumps ______________________________

German Measles _________________________

Chicken Pox ____________________________

Rheumatism ____________________________

Arthritis ______________________________

Tuberculosis ___________________________

Bilharzia ______________________________

Whooping Cough _________________________

Scarlet Fever ___________________________

Heart Disease ___________________________

Malaria ________________________________

Glandular Fever _________________________

2. Does your child suffer from …

Poor Vision? ____

Poor Hearing? ____

Poor Speech? ____

3. What other illness has your child had?

____

____

____

____

4. Is your child suffering from any illness/ailment at present, or of a potential on-going nature e.g. epilepsy, asthma, diabetes, migraines? Give details, including any routine medication:

____

____

5. Has your child had any operations? Give details.

____

____

6. Does he/she suffer from any **allergies** e.g. beestings, aspirin etc.? Give details, including any medication:

____

____

____

7. Are there any reasons why your child should not participate in sport or physical education?

   Give details: ____

____

____

8. Hay your child ever suffered a concussion or head injury, or any other sport/accident related injury e.g. knee, shoulder etc.?

   Give details: ____

____

9. Has your child been immunised against the following? **IMMUNISATION/CLINIC RECORDS MUST BE ATTACHED.**

   BCG (Tuberculosis) ____________________________

   Poliomyelitis: ________________________________

   DPT (Diphtheria, Whooping Cough, Tetanus): ______________________

   MMR (Measles, Mumps, German Measles): _______________________

   Hepatitis A _______________ Hepatitis B _______________ Chicken Pox ______________

   "**Age 12**" Tetanus, Polio, Diphtheria (Adacel Quadra) ____________ Date administered ______________

PLEASE NOTE that it is the RESPONSIBILITY OF THE PARENT/GUARDIAN

to supply the school with ALL NECESSARY INFORMATION regarding their child's health.

WHERE NECESSARY, please ensure that MEDIC ALERT BRACELETS ARE WORN.

Sign (Parent/Guardian) ____________________________ Dated: __________________________

EMERGENCY SURGERY CONSENT FORM

I, ____

(full name of parent/guardian)

hereby give my consent to the performance of an operation of such manner as the surgeon in his discretion considers necessary upon

____

(full name and surname of child)

and to the administration of such anaesthetics as may be required.

______________________________ ______________________________

Signature of parent/guardian giving consent | Relationship to Patient

______________________________ ______________________________

Date | Signature of Witness

EMERGENCY CONTACT DETAILS
(Should either parent/guardian not be available)

Contact Person (1) ______________________________

Tel: Cell

Contact Person (2) ______________________________

Tel: Cell

GRANTLEIGH

MEDICATION INDEMNITY FORM

THIS FORM NEEDS TO BE COMPLETED AND SIGNED BY YOU BEFORE WE ARE ALLOWED TO TREAT YOUR CHILD

CHILD'S SURNAME: ______________________________

CHILD'S FIRST NAME(S): ______________________________

DATE OF BIRTH: ______________________________

KNOWN ALLERGIES: ______________________________

____

____

I, the undersigned, hereby grant permission for any basic medication, as approved by the school doctor, to be administered to my child by the Grantleigh San Sister.

____
Signature of parent/guardian

______________________________ (Please print clearly)
Full name and surname of parent/guardian

____
Date

CHRONIC/PRESCRIBED MEDICATION CONSENT FORM

The following form needs to be completed in order for the San Sister and/or Boarder Parents to administer Chronic or prescribed medicine to your child; this includes natural and homeopathic medication/remedies.

Child's full name: ____

Date of Birth: ___________________________________

Allergies: ____

____

Please list medication below or attach a copy of the script:

____

____

____

____

____

____

I, the undersigned, hereby grant permission for the above Chronic or prescribed medication to be administered to my child by the Grantleigh San Sister.

_________________________________ _____________________________

Full name parent/guardian Signature parent/guardian

____

Date