



THE CODRINGTON SCHOOL

THE INTERNATIONAL SCHOOL OF BARBADOS

STUDENT'S HEALTH RECORD

The following information is most important to the school. Please complete all parts fully and accurately. This form must be completed and placed on file in the Clinic when the student enters school. This enables us to care for your child. Please inform the Office Manager/ School Nurse of any changes in the child's medical condition.

Child's first name			Middle name		Family name		
Boy	Girl	Age	Date of birth:	Day	Month	Year	
Nationality			Place of birth				
Name of child's doctor							
Doctor's business name and address				Doctor's emergency telephone number			
Emergency contact name		Relationship		Phone # Home Work Cell			

Medication permission

I hereby give permission for the above child to be given temporary medication by the school's administration, including Tylenol, Calpol, Motrin, cough medication and antacids.

Accident/illness treatment permission

I understand that, whilst every effort will be made to contact parents or guardians in the event of an accident or illness at school, sometimes emergency measures have to be taken immediately. I hereby give permission for emergency measures to be initiated in the case of accident to or sudden illness of this child. In the case that hospitalization is necessary I wish my child to be taken to Please advise if you prefer a specific medical centre; otherwise, the child will be taken to FMH Emergency Clinic in St Michael.



Please state the initial dates of the last immunization boosters of the following:

	<u>Date</u>	<u>Booster(s)</u>		<u>Date</u>	<u>Booster(s)</u>
Diphtheria			Hepatitis B		
Whooping cough (Pertussis)			Mantoux (TB skin test)		
Mumps			Polio		
Rubella			Tetanus		

Please circle below if this child has/had any of the following:

Allergies	Asthma	Congenital abnormalities	Convulsions/epilepsy	Ear infections
Frequent headaches		Hearing difficulties	Heart problems	Fainting
High/low blood pressure		Kidney/urinary infections	Diabetes	Tuberculosis
Orthopaedic problems		Rheumatic fever	Vision problems	Skin problems

Please comment on any circled items or any other conditions:

Does this child wear spectacles (glasses) or contact lenses?	Yes	No
Is this child under special medical care?	Yes	No
Does this child routinely take medicine?	Yes	No
Does this child have any problems which adversely affect her/his ability to study?	Yes	No
Is there any medical reason why this child cannot participate in physical education or sports?	Yes	No
Does this child have any known allergies to medication?	Yes	No
Is this child in good health, generally speaking?	Yes	No

If you have answered "yes" to any of the above questions, please give brief details below:

I hereby certify that all the information given on this form is correct, accurate and complete.

_____ Signature	_____ Date	_____ Relationship
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Please complete this form and return to the Office Manager/School Nurse before your child starts school. If there are any changes throughout the school year, please send the amended form. Thank you.