

**RVIS Student Health Record**

**Surname/Family Name:** ..... **First/Other Names:** .....

**Date of Birth:** ..... **Sex:** Male  / Female

**CPR Number:** .....

**Mother's Email Address:** .....

**Father's Email Address:** .....

**Mother's Mobile No.:** ..... **Father's Mobile No.:** .....

**Home Number:** .....

**Please complete the following, giving details where necessary:**

Is your child allergic to any medicine, food or product? (For example; penicillin, peanuts)

.....  
.....

Is your child taking any regular medication or is he/she receiving regular medical treatment? (For example; insulin, Ritalin, anti-epileptic medication, inhalers etc)

.....  
.....

Does your child have any specific health, behavioral or emotional problems?

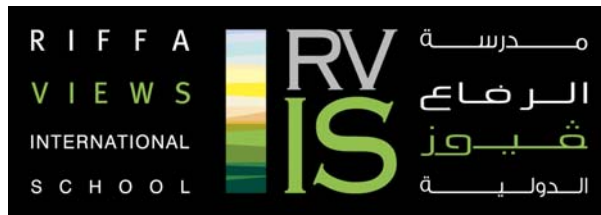
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Does your child have any hearing/hearing related problems? (For example, grommets)

.....  
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Does your child have any problems with eyesight or does he/she wear glasses?

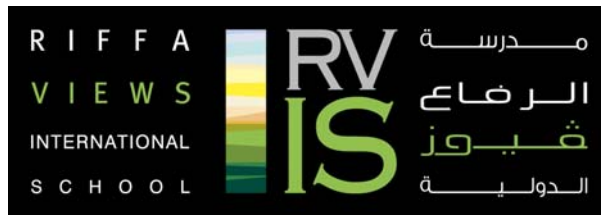
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**Has your child had or required treatment for any of the following childhood illnesses:**

**(If yes, please give a brief history)**

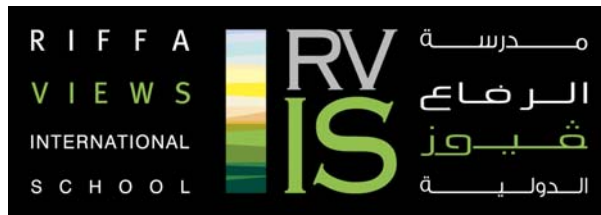
Condition	Yes/No	History
<b>Asthma / Hay Fever</b>	Yes/No	..... ..... .....
<b>Chicken Pox</b>	Yes/No	..... ..... .....
<b>Diabetes</b>	Yes/No	..... ..... .....
<b>Eczema</b>	Yes/No	..... ..... .....
<b>Epilepsy</b>	Yes/No	..... ..... .....
<b>Febrile Convulsions</b>	Yes/No	..... ..... .....
<b>G6PD (Glucose 6 Phosphate Dehydrogenase Enzyme Deficiency)</b>	Yes/No	..... ..... .....
<b>Hemophilia</b>	Yes/No	..... ..... .....



<b>Hepatitis</b>	<b>Yes/No</b>	..... ..... .....
<b>Hospitalization</b> – has your child ever spent time in a hospital	<b>Yes/No</b>	..... ..... .....
<b>Measles</b>	<b>Yes/No</b>	..... ..... .....
<b>Mumps</b>	<b>Yes/No</b>	..... ..... .....
<b>German Measles / Rubella</b>	<b>Yes/No</b>	..... ..... .....
<b>Persistent Headaches</b>	<b>Yes/No</b>	..... ..... .....
<b>Sickle Cell Anaemia</b>	<b>Yes/No</b>	..... ..... .....
<b>Other</b>	<b>Yes/No</b>	..... ..... .....

**Parent / Guardian Name:** ..... **Signature:** .....

**Date:** .....



## Consent Form

I **DO** consent to my child being given the following medication at school if necessary

- Calpol Syrup – For children under 6 years of age (Paracetamol suspension)
- Calpol 6 Plus Syrup – For children 6 years and over (Paracetamol suspension)
- Ibrufen (Brufen) Syrup
- Panadol (Paracetamol capsule)

Parent / Guardian Name: ..... Signature: .....

Date: .....

## Further Information

1. Please inform the school nurse as soon as possible if your child has been given any medication prior to coming to school
2. If your child is taking a prescribed course of tablets or medicine and is required to take it during school hours, please bring it to the nurse's office first thing in the morning. It can be collected from the nurse at the end of the school day. Please write clearly your child's name, class and the time and dosage of the medication to be taken. No medication is to be kept in school bags, desks, cubby holes or jackets.
3. Please notify the school nurse immediately should your child contract any communicable diseases or should there be any change in their overall health. This helps us to ensure that the health of your child and others in the school community is optimized.
4. It is extremely important to keep the school updated if there is any change in your contact details. Also, please inform the nurse and if necessary complete a new '**Emergency Contact Form**' if both parents are leaving the country whilst your children are still in school, to ensure that the school has the current contact details of your nominated emergency contact.