STUDENT MEDICAL CARD

Student's Name: _____

Medical Aid Name:_____

Medical Aid No.:_____

Medical Aid Contact Details:_____

Medical Aid Principal Member:_____

Doctor's Details: Name: _____

Surgery Address: _____

_____

Doctor's Contact No.: _____

Parent(s) Name:_____

Phone:_____ Emergency No:_____

Please inform us if the Student has special health needs.

Student Name:_____

Gender: Male _____ Female_____

Date of Birth_____

Parent/Guardian Phone_____

	Yes	No
Was your child born outside of South Africa?	☐	☐

Does your child have any of these conditions? (Please tick)

- ☐ Diabetes
- ☐ Asthma
- ☐ Seizures or epilepsy
- ☐ Behavior Concerns
- ☐ Headaches Often
- ☐ Heart problems
- ☐ Mental Health concerns, depression, ODD

☐ Poor hearing/sight, ear or eye problems

☐ Ear infections often or ☐ tubes in ears

☐ Learning difficulties like ADHD, ADD, or dyslexia

Medicine

☐ Does this child take medications at home every day?

☐ Does this child take medications often, but not every day?

☐ Will this child need medication at school?

Health History

☐ Has this child ever had Chickenpox? What year_____

☐ Has this child ever had to stay in the hospital overnight?_____

☐ Has this child ever had surgery? Explain_____

☐ Has this child been to the hospital or gone unconscious after a head injury or concussion?

☐ Does your child require a special diet? If yes, what kind?_____

☐ Is there any activity this child must avoid?_____

☐ Does this child use glasses, hearing aids, walker, leg braces or other adaptive devices?

Please add details from above, medications, or other concerns about this child's health Development, behaviour or home life:

Completed By_____

Relationship to Student_____ Date_____