Health History & Treatment Consent Form

Student's Name: Date of Birth:

Name of Parents and/or Guardians:

Home Address:

Phone Number: *Home* *Work*

Mobile *Other*

Nationality: Place and Country of Birth:

Travel Insurance Company: Policy No.:

Which of the following does your child suffer from?

ADD or ADHD	Diabetes	Malaria
Allergies to anaesthetics	Ear infections	Mononucleosis
Allergies to penicillin	Eating problem/disorder	Muscular or joint pain/issues
Allergies to:	Glandular Fever	Rheumatic fever
Anaemia	Haemophilia	Seizures/epilepsy
Artificial heart valves/joints	Hay fever	Sinusitis
Asthma	Heart defects/murmur	Skin disorder (eczema, psoriasis)
Bed-wetting	High blood pressure	Sleepwalking
Blood disorders/sickle cell anaemia	Kidney disease/problems	Tonsillitis
Cancer	Learning disabilities/special education	Tuberculosis/lung disease

What other medical conditions does he/she have?

Is he/she receiving medical treatment at present? Yes No

If Yes, give details:

Details of all vaccinations:

Authorization To Treat

I declare that this health history is accurate. I permit my child to engage in all prescribed activities, except as noted by me. In the event that I cannot be reached in an emergency, I give my permission for my child to receive medical & dental treatment, including surgery, anaesthesia and medications as required.

Parent/Guardian Signature **Date**