

# Medical Information Form



THE **BRITISH SCHOOL**  
*Nursery*  
New Delhi, India



Dr. Jose P. Rizal Marg, Chanakyapuri, New Delhi 110021  
Tel.: +91 11 24102183, 24678524, 24671006, 24104931  
Fax: +91 11 26112363  
Email: admissions@british-school.org  
Website: www.british-school.org

## STUDENT HEALTH INFORMATION

**Name of Student:** \_\_\_\_\_  
First Middle Initial Last name (IN CAPITALS)

**Address:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Gender:** Male  Female   
Day Month Year

**Enrolment Date:** \_\_\_\_\_ **Age as on 1st September** \_\_\_\_\_  
(Of year of joining the School)

## EMERGENCY CONTACT DETAILS

### Father's

Name \_\_\_\_\_

Father's Home Phone Number \_\_\_\_\_

Father's Mobile Number \_\_\_\_\_

Father's Work Phone Number \_\_\_\_\_

### Mother's

Name \_\_\_\_\_

Mother's Home Phone Number \_\_\_\_\_

Mother's Mobile Number \_\_\_\_\_

Mother's Work Phone Number \_\_\_\_\_

In the event of an emergency and neither parent can be contacted, I give permission for the following people to be contacted and act upon the parent's behalf.

Name \_\_\_\_\_

Relationship to child \_\_\_\_\_

Address \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Mobile Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Name \_\_\_\_\_

Relationship to child \_\_\_\_\_

Address \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Mobile Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

# Medical Information Form

1. Does your child suffer from any allergies? Yes/No.

If yes, please list e.g. certain foods, adhesive tape, bee stings, environmental substances or other.

Allergy/Asthma	What happens? How severe?	Any medications taken for allergy/asthma?

Please fill in the asthma/allergy information form in the health office after your arrival.

2. Does your child have any problems during physical activity? For example: joint or muscle problems, irregularity of heart beat, trouble in breathing or coughing, heat related problems, chest pain, others? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Does your child take regular medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list medication details:

Name of Medication	Reason for Medication	Dosage	Prescribing Doctor	Medication Review Date

Any medication to be given whilst in school must be delivered to the school nurse personally, with written instructions from the Doctor regarding dose/administration.

4. Has your child been assessed by Early Intervention or received Early Intervention? For example: speech therapy, occupational therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes,

Name of Early Intervention \_\_\_\_\_

Duration of Intervention \_\_\_\_\_

Dates of Intervention \_\_\_\_\_

Intervention Outcome \_\_\_\_\_

# Medical Consent Form



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## MEDICATION PERMISSION (Please Check "✓" Yes or No)

**I give permission for the School Nurse to administer the medications listed below, without prior contact for permission. (Please tick appropriate box)**

1. Acetaminophen for headache or minor discomfort. \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
(Other names for this are Tylenol, Panadol, Paracetamol, Crocin)
2. Topical ointments or solutions for minor wounds, skin \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
irritations, and insect bites/stings  
(full list is available in the Health Office)
3. Cough syrup for cough \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
4. ELECTRAL — Rehydration \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Parent/Guardian:** \_\_\_\_\_

## PARENT AGREEMENT AND CONSENT (Please check "✓" each box)

- While I expect the school authorities to exercise reasonable precautions to avoid injury, I understand that the school has no financial obligation for any injury or illness that may occur during activities.
- I authorise the teacher/nurse to administer medications as described.
- I authorise the teacher/nurse to attain medical treatment and care for any injury or illness that may occur during activities.
- I further consent to emergency treatment of any sort deemed necessary by the first responding medical person (or by any physician designated by proper school authorities) for any illness or injury that may occur during activities, and I shall not hold him/her liable in a court of law.
- I understand that in the event of a medical emergency, every effort will be made to notify parents/guardian as soon as possible.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Parent/Guardian:** \_\_\_\_\_

# Immunisations

## REQUIRED IMMUNISATIONS PARENT/PHYSICIAN MUST PROVIDE DATES (day/month/year)

If any assistance is needed with this form, please contact our Nurse Supervisor at [nurse@british-school.org](mailto:nurse@british-school.org)

IMMUNISATIONS	1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose	4 <sup>th</sup> dose	5 <sup>th</sup> dose	TD (Over age 7)
Diphtheria, Tetanus, Pertussis — DTP, DTaP or DT						
Poliomyelitis						
HIB (Haemophiles Influenza Type b)						
MMR (Measles, Mumps, Rubella)			If the student has contracted measles or varicella (chicken pox) please note in the boxes.			
Measles (if given separately)						
Hepatitis B						

Recommended immunisations — Please fill in the year/s in which any of these were given.

Hepatitis A: 1 \_\_\_\_\_ 2 \_\_\_\_\_  
 Meningococcal: \_\_\_\_\_  
 Varicella (Chicken Pox): \_\_\_\_\_  
 Typhoid: \_\_\_\_\_  
 Rabies: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_  
 Japanese Encephalitis: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_  
 Others: \_\_\_\_\_

### THE FOLLOWING DETAILS MUST BE COMPLETED BY A LICENSED PRACTITIONER.

#### A: Tuberculosis Screening

TB screening must have been done within 12 months prior to entering *The British School, New Delhi*.  
 This requirement is waived if the child has had a BCG vaccination.

- BCG (Tuberculosis vaccination) if given: Date \_\_\_\_\_
- Please DO ONE of the following for students to provide evidence that the student is free from tuberculosis.  
 (A) PPD %TU Mantoux: Date \_\_\_\_\_ Result (mm induration) \_\_\_\_\_ OR  
 (b) Chest X-ray: Date \_\_\_\_\_ Result \_\_\_\_\_

#### B: Physical Examination

Date of Physical Examination \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Vision R \_\_\_\_\_ L \_\_\_\_\_ Normal \_\_\_\_\_  
 Referred \_\_\_\_\_

CLINICAL EXAM:	NORMAL	SIGNIFICANT HISTORY OR ABNORMAL EXAM: EXPLAIN
1. Skin		
2. Eyes		
3. Ears, Nose and Mouth		
4. Respiratory (asthma, other)		
5. Nutritional status		
6. Developmental status		
7. Surgery or serious illness		
8. Other		

Name of the Physician: \_\_\_\_\_ Signature: \_\_\_\_\_

Date \_\_\_\_\_

IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY THE SCHOOL NURSE IN WRITING ([nurse@british-school.org](mailto:nurse@british-school.org)) OF ANY CHANGES TO THE INFORMATION GIVEN IN THIS FORM.