



BROOKHOUSE SCHOOLS MEDICAL FORM

The School Health Room provides a First Aid service during school hours and at school functions for all students on the campus and for boarding students after school hours and during weekends. It is essential, therefore, that the school has up-to-date information about your child's health and medical requirements. Please complete and return this form as soon as possible and inform the school nurse in writing of any changes in circumstances.

Name of child: _____

Date of birth: _____ Date of Submission of this form: _____

Brothers/ sisters in the school:

Blood group (if known): _____

Medical Insurance Card (type and number): _____

** All students are expected to have full medical insurance prior to admission*

Name of Parent/ Guardian: _____

Parent/ Guardian contact numbers: In case of emergency: _____

Home: _____

Office: _____

Mobile: _____

Child's Doctor: _____ Doctor's Tel: _____

Doctor's Mobile: _____

- Please indicate (✓) whether your child has been inoculated against or has suffered from any of the following illnesses:

| Illness | Inoculated | Has had | Illness | Inoculated | Has had |
|----------------|------------|---------|-----------------|------------|---------|
| Chicken Pox | | | Whooping Cough | | |
| Measles | | | Mumps | | |
| German Measles | | | Malaria | | |
| Hepatitis | | | Glandular Fever | | |
| Bilharzia | | | Other | | |

- Please list any other immunizations your child has received:

- Please (✓) any of the following from which your child suffers:

| | | | | | | | | | |
|----------|--|-------------|--|-----------|--|-----------|--|----------|--|
| Eczema | | Asthma | | Sinusitis | | Hay Fever | | Migraine | |
| Epilepsy | | Bed wetting | | | | | | | |

- Please list below hospitalisation and operations that your child has undergone that you consider have any bearing on their current health or well being:-

● **Allergies:**

Please give details of all allergies (e.g. to food, medicines, antibiotics, nut allergy, bee stings, etc). The catering department will be able to include your child on the Allergy List for special dietary requirements.

● **Medicines administered at Brookhouse School:**

Please (✓) to indicate that you give permission for any of the following to be administered to your child at school, by the school nurse.

| | | | | | | | |
|----------------|--|-----------|--|-------|--|----------------------------|--|
| Calpol | | Piriton | | Vicks | | Panadol | |
| Gentian Violet | | Bronchium | | Actal | | Ventolin (for asthmatics) | |
| Buscopan | | Betadin | | | | All of the above | |

● In emergency cases, such as fractures and severe sprains, do you give permission for Rescue Remedy or Brufen to be given to your child? **YES / NO**

● Please give details of any hearing or sight difficulties that your child may have.

● Please give details of any other information concerning your child's past or present medical and/or dietary history, about which it would be useful for the school nurse to be aware.

● Please give details of any routine medication prescribed to your child (medicine and the condition for which it is prescribed).

● Is your child currently receiving, or have they received in the past, counselling from a psychiatrist, clinical psychologist or a counsellor? **YES / NO**

If yes, please ensure you discuss this with a relevant member of the senior staff at Brookhouse.

● If you cannot be contacted in case of emergencies, do we have your consent to call ambulance services to transport* your child to Nairobi Hospital? **YES / NO**

** In such circumstances parents will be billed by the school*

I hereby certify that this child is physically fit to participate in all school sports and activities on and off campus.

[In case of a negative answer, please specify the reason(s).]

Signature of Parent/ Legal guardian: _____

Name (please print): _____ Date: _____

PLEASE ADVISE THE SCHOOL NURSE IN WRITING OF ANY CHANGES TO THIS INFORMATION.