LJ WILD HOUSE
FAHS FEILDING HIGH SCHOOL

MEDICAL INFORMATION SHEET

Student's Name: _____

Parent or Legal Guardian Contact Details

1. Name: _____

   Address: _____

   _____

   Relationship: _____

   Telephone: Home _____ Work _____ Mobile _____

   Email: _____

2. Name: _____

   Address: _____

   _____

   Relationship: _____

   Telephone: Home _____ Work _____ Mobile _____

   Email: _____

Do you consent to your child being treated by a health provider (dentist / doctor) at the boarding hostel and at Matron's discretion? YES / NO

Community Services Card

Issue Date: _____ Expiry Date: _____

Number: _____

Signed: _____ Date: _____

Student's Name: _____

Date of Birth: _____

Has he / she had:

Measles	YES / NO	Recurring Tonsillitis	YES / NO
Mumps	YES / NO	Ear Infections	YES / NO
Chicken Pox	YES / NO	Glandular Fever	YES / NO
Whooping Cough	YES / NO	Appendicitis	YES / NO

Does he / she have:

Epilepsy	YES / NO	Diabetes	YES / NO
Hay Fever	YES / NO	Asthma	YES / NO
Sight Problems	YES / NO	Bed Wetting	YES / NO
Sleep Walk	YES / NO		
Mental Health	Anxiety / Panic Attacks / Depression / Self-Harm (Please circle)		

Long Term Medication: _____

_____

Any Allergies (food / medication): _____

_____

Any further health problems we should be aware of: _____

_____

Particulars of Inoculations and Vaccinations:

Tetanus Date: _____ IPV Date: _____

Family Doctor:

Name: _____

Contact: _____

Family Dentist:

Name: _____

Contact: _____