IVY LEAGUE ACADEMY

HEALTH FORM

Blood Group & RH Factor

Name_____

Academy No_____ Class _____

Father's Name _____

Mother's Name_____

Date of Birth_____ (dd/mm/yy)

Inoculated Against	
	Tick
Tetanus Toxoid (BCG)	
Measles	
Rubelia	
Polio	
Diphtheria	
Hepatitis - B	

IN CASE OF EMERGENCY PLEASE CONTACT

Name_____ Language Spoken_____

Telephone: _____ or _____

Address:_____

FAMILY HEALTH HISTORY

(Indicate any occurrence of the following among family members)

	Yes	**No**		**Yes**	**No**
Asthma			Cancer		
Diabetes			Epilepsy		
Heart Disease			High Blood Pressure		
Kidney Disease			Mental Illness		
Rheumatic Fever			Tuberculosis		

Has there been a death of a close family member in the last year? _____ Date _____
relation to the student_____ Cause _____

PERSONAL HEALTH HISTORY

(Indicate if the student now has/had any of the following)

	Yes	**Date**		**Yes**	**Date**
Childhood Diseases			**Heart/Blood Disorder**		
Chicken Pox			High Blood Pressure		
Jaundice			Hemophilia		
Rheumatic Fever			**GI/GU Conditions**		
Tuberculosis			Appendicitis		
Typhoid			Abdominal pain		
Ear/Nose/Throat			Frequent Indigestion		
Frequent Colds			Bed Wetting		
Frequent earaches			**Skin Conditions**		
Draining ears			Eczema		
Frequent nose bleeds			Frequent boils		
Frequent sore throats			Scabies		
Tonsillitis			**Neurological Conditions**		
Any deafness			Convulsion/Epilepsy		
Tooth/Gum problems			Dizziness/Fainting		
Hay fever Allergies			Frequent Headaches		
Chest/Respiratory			Psychiatric treatment		
Asthma					

Does the student: Wear glasses or contact lenses? _____

If so please submit a copy of prescription for glasses or contact lenses.

Wear a hearing aid? _____

Having on going dental treatment now? _____

If answer is "yes" please tick one of the following:

a) Treatment will be completed while at home during vacation.
b) Treatment to be continued by orthodontist or dentist recommended by Ivy League Academy .....

ALLERGIES -- TOWARDS DRUGS, FOOD OR OTHERS – YES / NO

If 'yes' please state which drug and treatment that has been or is being given.

_____

KNOWN MEDICAL CONDITIONS

Does your child suffer with any medical conditions for which he/she takes medication to control symptoms? E.g. asthma, skin conditions etc. If your answer is "yes" please give details:

Condition: _____

Date of Diagnosis: _____

Please record any other illness/injury or operations your child has undergone.

Illness: _____

Date: _____

Injury:--Nature _____

Date:_____

Operations: -- Nature _____

Date: _____

I declare that all the details given in this form are true and correct.

Name of the Parent:_____

Signature: _____

Date: _____

LEGAL CONSENT STATEMENT – MUST BE SIGNED

I _____ authorize Ivy League Academy to arrange for the necessary medical tests, treatment, or emergency procedures such as surgery, diagnostic examinations, the administration of any anesthetic (general, spinal or local) and blood transfusion, which may be necessary for my child _____ during his stay at Ivy League Academy.

This will be based on the professional judgement of licensed medical and nursing personnel of Ivy League Academy or any other licensed Professional to whom it may be necessary to refer my child.

Name of the Parent: _____

Signature: _____ Date: _____