De Paul Public School

HEALTH FORM - I

Admission Number:

Personal Information of the Child seeking Admission:

Student Name

Date of Birth Male Female Blood group

Emergency Contact No

Preferred Doctor (if any) Mobile No

	Name	Grade
Sibling(s) at DPPS		

MEDICATION PERMISSION

I give my consent to the School nurse to administer over the counter medication for the common aliments. I am conscious of the fact that medication rarely may produce unwanted side effects.

Yes No

EMERGENCY PERMISSION

I give my consent for emergency measures to be taken in case of an emergency arising due to an accident/violent injury/medical or surgical emergency with the understanding that I (the father/ the mother/ the guardian of the student) shall be notified/informed as soon as possible. The School will accept no responsibility for any unforeseen incident that may occur due to the administration of medicine/treatment in both emergency situations, though necessary precautions are taken.

Signature of Parent Date

De Paul Public School

HEALTH FORM - II

[*to be filled by the parent*]

Admission No

Did your child have any of the following ailments in the past:(tick '√' the appropriate)

Measles	☐	Diabetes	☐	Typhoid Rubella (German measles)	☐
Malaria	☐	Chickenpox	☐	Mumps	☐
Goiter/Thyroid	☐	Allergies	☐	Jaundice	☐
Eczema	☐	Epilepsy/Seizures	☐	Tonsillitis	☐
Meningitis	☐	Poliomyelitis	☐	Rheumatic Fever	☐
Asthma	☐	Pleurisy	☐	Heart Murmurs	☐
Discharging ears	☐	Tuberculosis	☐	Kidney Stones	☐
High blood pressure	☐			Bladder or kidney infection	☐

OTHER SPECIFIC SYSTEMIC ILLNESS (*if any*): Please give details

NOTE: *If a Child suffers from rheumatic heart disease/bronchial asthma/epilepsy/endocrine disorder/allergy to food, medicines etc., has illness which requires long term medication, please furnish details of the illness giving frequency, severity of disease etc., and a photocopy of the heath records and treatment being administered. This should help the School to understand his/her illness better and should help in better management of the child as and when demand.*
Any other relevant information:

Please check if any relative (parent, siblings, grandparents) have had any of the conditions listed below:

Asthma		Obesity		Kidney disease		Heart disease	
High blood pressure		Diabetes		Seizures/Epilepsy		mellitus	
Bleeding Tendencies		Cancer		Tuberculosis		Psychiatric illness	

Signature of Parent

Date