Suid-Natal High School

LEARNER HEALTH FORM

THIS INFORMATION IS REQUIRED FOR EACH LEARNER
THAT PARTICIPATES IN A SCHOOL ACTIVITY

STRICTLY CONFIDENTIAL:

LEARNER DETAILS:

Name & Surname:	Gr:
Cell:	ID:

PARENT/GUARDIAN DETAILS:

Name of Father	Tel:
Name of Mother:	Tel:
Postal Address:	
Postal Code:	

MEDICAL AID DETAILS:

Main Member Name & Surname:	
Family dr:	Tel nr:
Name of Medical Aid:	
Medical Aid nr:	

MEDICAL HISTORY:

- Is your child subject to seizures, fainting, epilepsy, diabetes or any other condition that may affect his or her safety during the excursion/ Trip, tour or activity? **YES/NO** Please give details:

  _____

IS YOUR CHILD ALLERGIC TO:

- Penicillin [Please give details] _____
- Any other drug: _____
- Any food: _____
- Other: _____

MEDICATION:

- Parents/guardians are requested to make arrangements with the trip/excursion/activity committee for the safe keeping and handling of prescribed medications prior to the excursion.
- Is your child presently taking tablets and/or other forms of prescribed medication? **YES/NO**
- Does your child self-administer the medication? **YES/NO**
- If "yes", state name of medication, dosage and frequency of use:

  _____

OTHER INFORMATION:

- Please provide any other information about your child which will enable the organisers of the excursion/activity to provide better care for your child.

  _____

  _____

SIGNATURE: _____ DATE: _____