



COLEGIO SAGRADO CORAZÓN DE JESÚS

Medical Questionnaire

(This form must be completed and signed by the Parent or Guardian)
(One per Student)

Student Name: _____ **Grade** _____

Medical History of Student	Yes	No
1. Has a doctor ever denied or restricted your child's participation in sports for any reason?		
2. Does your child have any rashes or other skin problems?		
3. Has your child ever had a seizure?		
4. Does your child have headaches when exercises?		
5. Does your child have allergies to medicines, pollens, foods or stinging insects? Please give details of any known ALLERGY, including sensitivity to drugs, insect bites, stings, sticking plaster or particular foods:		
6. Has your child ever had numbness, tingling, or weakness in the arms or legs after being hit or falling?		
7. Has your child had any problems with the eyes or vision?		
8. Has your child had any broken or fractured bones or dislocated joints? Have your child ever had surgery? If affirmative, please state which surgery		
9. Please indicate whether or not you authorize for your son/daughter to be given simple "over the counter medicine" while in school for the relief of musculoskeletal pain, headaches or menstrual pain, and fever. Please indicate the medication and dose you authorize:		
10. Certain medical conditions may require information to be given to relevant members of staff. Do you give your consent to the nurse exercising her professional judgment in this matter?		
11. In the unlikely event of a medical emergency arising in which it proves impossible to get in touch with you, do you give the school authority to act on your behalf?		

It would be greatly appreciated if you could please keep the School Nurse updated, either by telephone or in writing, regarding any changes in your son/daughter's health and/or treatment he/she receives, to assist us in giving her the best possible care.

Name of Parent/Guardian

.....

Signature of Parent/Guardian

..... Date