



# Hamilton Boys' High School

Argyle House  
Medical Information and Permission forms



# Argyle House

## Confidential Medical Information and Permission forms

This form must be completed before an application for a position in the Hostel can be considered. It requires verification from a doctor. We recommend you seek your doctor's help to complete this form. This form will be retained in the hostel. All students at Argyle House are enrolled as patients at Hamilton East Medical Centre. A photocopy of this form will be passed on to the Hamilton East Medical Centre should the need arise.

The information given by you will be used solely for the purpose of providing appropriate medical care to your son. The information will not be disclosed by the school to anyone other than an authorised medical practitioner who is attending to the health needs of your son.

1. STUDENT DETAILS		(please complete all sections)	
Student's full name:	<input type="text"/>		
	(Surname)	(Christian names)	
Address:	<input type="text"/>		
Date of birth:	<input type="text"/>		

2. FAMILY DETAILS			
Father's full name:	<input type="text"/>		
	(Surname)	(Christian names)	
Address:	<input type="text"/>		
Telephone numbers:	<input type="text"/>		
Mother's full name:	<input type="text"/>		
	(Surname)	(Christian names)	
Address:	<input type="text"/>		
Telephone numbers:	(work)	(home)	(mobile)
Emergency contact's name :	<input type="text"/>		
Telephone numbers:	(work)	(home)	(mobile)

### 3. MEDICAL INFORMATION

Community Services Card: Yes  No  If yes please attach a copy

Medical Insurance: Yes  No

### 4. MEDICAL HISTORY

IMMUNISATIONS	Date Immunised		Date Immunised
DTaP* (6 weeks)		DTaP (3 months)	
DTaP (5 months)		DTaP (15 months)	
Polio (OPV) (6 weeks)		Polio (OPV) (3 months)	
Polio (OPV) (5 months)		Polio (OPV) (15 months)	
MMR* (15 months)		MMR (11 years)	
Hepatitis B (6 weeks)		Hepatitis B (3 months)	
Hepatitis B (5 months)		Td (11 years)	

\* DTaP = Diphtheria, Tetanus, acellular Pertussis \* MMR = Measles, Mumps, Rubella

\* Td = Tetanus, adult dose diphtheria

#### CURRENT MEDICAL CONDITIONS

Please outline any medical condition which your child has and explain the appropriate course of action that Hostel staff should follow if he should experience the condition whilst at Argyle House.

#### DETAILS OF CURRENT MEDICATION

Has your child had any of the following conditions: (Give details and stage age when it occurred if possible)

Details		Details	
Headaches		Asthma	
Measles		Earache	
German Measles		Bronchitis	
Diphtheria		Frequent colds	
Pneumonia		Glue ear	
Whooping Cough		Phobias	
Rheumatic Fever		Tonsillitis	
Mumps		Skin disorders	
Hepatitis		Bed wetting	
Poliomyelitis		Heart problems	
Scarlet Fever		Epilepsy	
Leptospirosis		Others	
Tuberculosis			
Sinustis			
Hay fever			

#### 4. MEDICAL HISTORY continued

Does your son suffer from any allergies to medicines/foods/plants/insect bites or stings? Yes  No   
(If yes please specify)

#### FAMILY HISTORY

Is there any family history of chronic medical conditions such as heart disease, asthma, tuberculosis, epilepsy? (If yes please give details) Yes  No

#### SPECIALIST MEDICAL CARE

Please give details of any specialist(s) attending your son and provide their name(s) and address(es):

Signature of Doctor:  Date:

Signature of Parent/  
Guardian:  Date:

#### PERMISSION TO ADMINISTER DRUGS OBTAINED FROM CHEMIST

Permission to administer prescription drugs obtained from the chemist.  
I hereby give permission for a staff member of Argyle House to administer \_\_\_\_\_  
(please specify the name of the drug(s)) to my child should the need arise.

Signature of Parent/  
Guardian:  Date:

#### PERMISSION FOR MEDICAL TREATMENT

I hereby give permission for my sone to be attended by a doctor or taken to a hospital if the supervising staff of Argyle House consider it necessary. I hereby authorise the supervising staff in charge to permit my child to be given general anaesthetic and to be operated on in the case of a medical emergency if such treatment is considered necessary by a qualified medical practitioner. This permission is given provided that every effort will be made to contact me personally before any decision is made to operate. NB Such a decision will be made by staff only where there is a medical emergency and where every possible effort to contact me has failed.

Signature of Parent/  
Guardian:  Date: