

Alexandra College Medical Report & Consent for Students

Student Surname: _____ First Name(s): _____

Home Address: _____

_____ Date of Birth: ____/____/____

Mother Work/Mobile No: _____ Father Work/Mobile No: _____

Emergency Contact Name: _____ Telephone Number: _____

*Guardians Name: _____ Telephone No: _____ (Boarding students only)

Immunisations & Infectious Illnesses* (Please tick and give dates) Resident Students only

Immunisation	Date	✓	Infectious Illnesses	Date	✓
BCG			Whooping Cough		
Polio			German Measles		
MMR			Diphtheria		
H.I.B			Scarlet Fever		
Meningitis			Glandular Fever		
Pneumococcus			Hepatitis A/B/C		
Diphtheria, Tetanus, Pertussis			TB		
Mumps			Rheumatic Fever		
Measles			Other		
Chicken Pox					

Allergies (please list & give details of treatment required e.g. Antihistamine, Anapen)

Medications: _____

Foods: _____

Other: _____

Treatment Required:

Student Health History

	Yes	No		Yes	No
Anaemia or Blood disorders			Frequent colds or chest infections		
Asthma			Frequent sore throats		
ADD/ADHD			Hay fever		
Bone Fractures			Heart problems		
Coeliac Disease			Headaches/Migranes		
Depression			Menstrual problems		
Diabetes			Nocturnal enuresis(Bed wetting)		

* Refers to Boarding Student only

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Dental Problems			Nosebleeds		
Eczema/Skin problems			Scoliosis		
Ear problems			Speech problems		
Eating Disorders			Surgeries/Hospitalisations		
Epilepsy/History of seizures			Urinary tract infections		
Eye problems			Other		

Please tick above & give details if yes: _____

Can normal school activities & sport be undertaken? Yes No

If NO, please explain (including specific restrictions):

*Name of Family Doctor: _____ Tel No: _____

Address: _____

Health Insurance Details if any: _____

NB. Students from EU member states should obtain & bring with them a current European Health Insurance Card. This will ensure that no charge will be made for GP visits, prescriptions etc. during their stay in Ireland.

Parental Consent to Treat & Request to Administer Medication

Prescription Medications

Please list prescription medications, the dosage & frequency that your daughter is currently taking (including inhaler, emergency medications e.g. Anapen)

Condition requiring medication _____

Name(s) of medication & specific dosage(s) required (ml or Tablet)

1. _____

2. _____

I/We request that my/our daughter be given the above medication in the specified dosages.

I/We give consent for my/our daughter (print) _____ to receive first aid treatment & appropriate over the counter preparations for the relief of minor illness symptoms.

I/We further agree that should any emergency treatments or operation become necessary when we are not immediately available may be undertaken on the advice of attending doctor, school doctor or hospital doctor. In an emergency requiring medical attention I/we can be contacted at the telephone numbers below:

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Mother's Signature: _____ Tel No: _____

Print Name: _____

Father's Signature: _____ Tel No: _____

Print Name: _____

Date: ____/____/____