ALEXANDRA COLLEGE
DUBLIN

# 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: _____

*Guardian's 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, Epipen)

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/Migraines | | |
| Depression | | | Menstrual problems | | |
| Diabetes | | | Nocturnal enuresis (Bed wetting) | | |
| 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):

_____
_____

Is there anything the school should be aware of that may impact your daughter's mental wellbeing? (e.g. anxiety, depression, etc.)

☐ Yes ☐ No.
Details:_____

*Name of Family Doctor: _____ Tel No:_____

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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.

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## 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. Epipen)

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 mediation 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:**

**Mother's Signature:** _____ **Tel No:** _____

**Print Name:** _____

**Father's Signature:** _____ **Tel No:** _____

**Print Name:** _____

**Date:** _____/_____/_____