AISM HEALTH HISTORY AND CONSENT FORM

STUDENT'S FIRST NAME _____ STUDENT'S LAST NAME _____

GRADE _____ SCHOOL YEAR _____

PARENT/GUARDIAN CONTACT INFORMATION

MOTHER NAME _____ FATHER NAME _____

CELL NO _____ CELL NO _____

CURRENT MEDICAL ISSUES

	*YES	NO	TREATMENT
ADHD			
Allergies			
Asthma			
Autoimmune disease			
Back pain			
Cardiac disorder			
Diabetes			
Drug sensitivities			
Epilepsy/Seizures			
Frequent ear infections			
Frequent headaches			
Head injury (Concussion)			
Hearing problems			
Joint or bone problems			
Kidney / Bladder disorder			
Other			
Psychological Issues			
Skin disorder			
Severe allergies			

*For all YES answers, describe relevant symptoms

_____

_____

_____

_____

Is emergency treatment or medication to be stored at school? YES ☐ NO ☐

NAME OF MEDICATION	DOSAGE	TIMES ADMINISTERED

Clearly label medication with student's name and grade.

Does your child wear glasses / contact lenses YES ☐ NO ☐

Does your child have a hearing device YES ☐ NO ☐

Name of Medical Provider and Membership Number _____

I, the undersigned, authorize my child to be taken to the nearest hospital in case of an emergency.

I shall not hold AISM liable for any expenses, claims, loss or damage that may arise because of such action.

PARENTAL CONSENT

I _____, authorise AISM Health Services to administer non-prescription medication for minor ailments (e.g. Paracetamol, Ibuprofen, lozenges, antiseptic and anti-inflammatory creams and anti-histamines) to my child.

YES ☐ NO ☐

DATE _____ PARENT / GUARDIAN SIGNATURE _____

Please Note: All <u>new</u> students must attach a copy of their vaccination records.