



Student Health Services
Academic Year 2008 -2009
Canadian International School – Bangalore

Student Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Mobile #: _____

Name: _____ Number(s): _____

Emergency Contact: _____ Mobile #: _____

Family Doctor's Name: _____ Mobile #: _____

Known Allergies: _____

Medications (Currently Taking): _____

Medical Problems/Special Concerns/Medication if any: _____

Please attach a copy of up to date immunization / vaccination records.

Treatment:

If your child presents symptoms of illness that may require treatment, every effort will be made to contact parents/guardians/emergency contact. No medications are given without parental consent.

If you want your child given any of the following medications, if needed, please put your initials next to those medications.

For fever and/or pain: _____ Acetaminophen _____ Paracetamol _____ Ibuprofen

For Dehydration: _____ Electrolytes _____ Glucose Water

For Diarrhoea and/or Stomach Pain: _____ Sporlac _____ Digene

For Vomiting: _____ Vomit Stop (Domperidone)

For Allergic Reaction: _____ Cetirizine _____ Epinephrine Injection (for acute reactions: Bee Stings)

Do Not Give Any Medication: _____

Parent's /Guardian's Name: _____

Signature: _____ Date: _____