

Associazione Culturale Aurora
Student's Medical Form - Confidential

Student's name: _____

Male Female

School: _____

Class: _____

Date of Birth: _____

Home Address: _____

Emergency Contact:

Name of parent/guardian: _____

Relationship: _____

Phone numbers (H) _____ (W) _____ (M) _____

Medical History:

Please indicate any medical information, which should be known: _____

Is your child on any medication? _____

Please circle either yes or no to indicate if your daughter/son suffers from any of the following:

Asthma: Yes / No

Allergies: Yes / No

Diabetes: Yes / No

Epilepsy: Yes / No

Any serious injuries/illness in the last 12 months: Yes / No

Medicare No: _____ Valid to: _____

Doctor's Name: _____

Telephone: _____

I declare that the information which I have provided on this form is complete and correct and that I will notify the school if any changes occur.

Parent's Signature: _____ Date: _____