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: _____