

## STUDENT MEDICAL HEALTH FORM

(To be completed **July or August** annually)

CONFIDENTIAL

STUDENT'S FULL NAME:	PAEDIATRICIAN'S FULL NAME & TELEPHONE:
DATE OF BIRTH:	

**THIS SECTION MUST BE COMPLETED BY A DOCTOR/PAEDIATRICIAN REGISTERED IN THE GREEK MEDICAL SYSTEM**

IMMUNISATION RECORD (Please indicate year of immunisation or last booster)			
<b>DTaP/Tdap</b> (diphtheria, pertussis, tetanus)	<b>MMR</b> (Measles, Mumps, Rubella)	<b>Hep B</b> (Hepatitis B)	<b>Hep A</b> (Hepatitis A)
<b>BCG</b> (Tuberculosis)	<b>IPV</b> (Polio)	<b>Hib</b> (Hemophilus Influenza Type B)	<b>PCV</b> (Pneumococcal)
<b>(MCC, MCV4, MenB-4C)</b> Meningitis	<b>VAR/MMRV</b> (Measles, Mumps, Rubella, and Varicella)	<b>(RV1/RV5)</b> (Rotavirus)	<b>Mantoux</b>

**MEDICAL HISTORY (Please check the ones (if any) that apply to this student, providing details)**

Heart Disease	Kidney Disease	Diabetes	Epilepsy/Convulsions
Tuberculosis	Hearing	Eyesight	Allergies
Asthma	Other (please state):		

Can this student participate in all school activities, including swimming (please circle)?

**Yes / No**

**Doctor's Name, Signature and Stamp** \_\_\_\_\_

**Date:** \_\_\_\_\_

**IMPORTANT NOTICE:** This form contains sensitive data held for the purpose of emergency medical care and student welfare. It is stored securely and shared only with authorized personnel. To comply with GDPR retention policies, this document will be permanently destroyed in August 2027.

**THIS SECTION MUST BE SIGNED BY THE PARENT/GUARDIAN**

1. **Medication:** All medication that has to be administered during school hours must be accompanied by a doctor's prescription. Medication will be **properly labelled and stored in the Nurse's Office**. Instructions regarding dosage (dose and timing) must be clearly written and signed by the doctor.

**Condition:**

**Medication:**

**Dosage:**

**Time taken:**

2. **Parental Consent:** I give permission for my child to be given medication (paracetamol or ibuprofen) for a headache, fever or sore throat (please circle and state the dose).

**Yes / No**

**Dose:**

3. In the event that I cannot be reached, I give my permission for the school to proceed with emergency medical treatment, if required (please circle).

**Yes / No**

**Emergency contact name:**

**Emergency contact number:**

**SIGNATURE OF PARENT OR GUARDIAN:**

**DATE:**