CAMPION SCHOOL
Athens

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Please use this form to report your child's health to the school which is required by the Ministry of Education.
A licensed medical professional (General Practitioner or Paediatrician) completes part 5.
Without this paper and immunization record your child cannot actively participate in Physical Education lessons.

Part 1: Child's Personal Information | To be completed by parent/guardian.		
Child's Name:	**Date of Birth:**	**Year Group:**
Home Address:	**Gender:** **Male** ❑	**Female** ❑
Parent/Guardian 1:	**Parent/Guardian 2:**	
Mobile:	**Mobile:**	
Home Phone:	**Home Phone:**	
Email:	**Email:**	
Emergency Contact Name 1:	**Relationship to Child:**	**Mobile:**
Emergency Contact Name 2:	**Relationship to Child:**	**Mobile:**
I give permission to the signing health examiner/facility to share the health information on this form with my child's school. I understand that this form should be completed -**annually-** and returned to my child's school. **Parent's/Guardian's Signature:**_____ **Date:** _____		

Part 2: Parental Consent (at the school's discretion) I give permission for my child to be given: | To be completed by parent/guardian.	
❑ Paracetamol ❑ Ibuprofen ❑ Antihistamines ❑ Throat Lozenges (Strepcils)	**In the event that I or my emergency contact cannot be reached, I give my permission for the school to proceed with emergency medical treatment, if required.** ❑ Yes ❑ No

Part 3: Immunization Information | To be completed by parent/guardian.	
Immunizations	**Please provide in a copy of Immunization (MM/DD/YY)**
❑ The child is **up to date with immunizations** and a copy will be submitted from the parents/guardians. ❑ The child is **not up to date with immunizations** and a copy will be submitted from the parents/guardians. ❑ The child has not been vaccinated.	

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Part 4: Child's Health History, Exam, and Recommendations | To be completed by parent/guardian.

Does the child have any of the following health concerns? *(Check all that apply and provide details below)*

- ❑ Allergies
- ❑ Asthma
- ❑ Diabetes
- ❑ Heart Problem
- ❑ Seizures
- ❑ Surgical Procedures
- ❑ Vision problems /wear glasses
- ❑ Autism
- ❑ Behavioral
- ❑ Development
- ❑ Language/Speech
- ❑ Obesity
- ❑ Premature
- ❑ Failure to thrive
- ❑ Emotional concerns
- ❑ Hearing difficulties
- ❑ Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
- ❑ Significant health history, condition, communicable illness, or restrictions.
- ❑ **Other:**_____

Provide details.
If the child is currently undergoing medical treatment or has been referred for treatment, please attach a completed Medication/Medical Treatment Plan form:

_____

Part 5: Licensed Health Practitioner's Certifications| To be completed by a licensed General Practitioner or Paediatrician.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, sports activities, tournaments, trips or extra-curricular activities. If no, please explain what he/she can and cannot do. _____	❑ No	❑ Yes
This child is cleared for **competitive sports.**	❑ No	❑ Yes

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

General Practitioner or Paediatrician Office Stamp	**Doctor's Name:**
	Doctor's Phone:
	Doctor's Signature:
	Date: