

# STUDENT HEALTH, EMERGENCY CONTACT, AND TREATMENT FORM



THE  
PREMIA  
ACADEMY

Name of Student \_\_\_\_\_

Birth Date (DD/MM/YYYY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender M ☐ F ☐

Blood Group \_\_\_\_\_ Sibling(s) at The Premia Academy \_\_\_\_\_

## PRIMARY PARENT/GUARDIAN INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_ Phone No. \_\_\_\_\_

## SECONDARY PARENT/GUARDIAN INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_ Phone No. \_\_\_\_\_

## LOCAL EMERGENCY CONTACTS

(Adults, 18 years or older, who may be contacted in the event of an emergency):

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_ Phone No. \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_ Phone No. \_\_\_\_\_

I hereby permit the staff of The Premia Academy to secure emergency medical treatment for our child while under their supervision:

Name of Child's Pediatrician and Hospital \_\_\_\_\_

Street Address, City, State, Postal Code/PIN \_\_\_\_\_

Phone Number / After Hours Emergency Number \_\_\_\_\_

Preferred Hospital for Emergency Treatment \_\_\_\_\_

Health Insurance Policy Name and Number \_\_\_\_\_

Please list critical health issues if any \_\_\_\_\_

Please list allergies if any \_\_\_\_\_

In the event of emergency medical treatment (emergency measures to be taken in case of a situation arising due to an accident/violent injury/medical or surgical emergency) is required, I give consent for my child to be transferred to the nearest medical facility and if necessary to be treated by a qualified pediatrician. If I cannot be contacted and if my designated emergency contact is not available, I understand and agree that The Premia Academy will contact emergency response for emergency medical assistance for which I will be financially responsible. The school will accept no responsibility for any unforeseen incident that may occur due to the administration of medicine/treatment in both emergency and non-emergency situations, though necessary precautions are taken.

Parent/Guardian First and Last Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## STUDENT'S HEALTH HISTORY (TO BE FILLED IN BY A PEDIATRICIAN)

Alternately, parent can attach photocopies of the immunization record with dates duly signed by a pediatrician.

### IMMUNIZATION HISTORY

Children must have completed their childhood minimum vaccination requirements for their age as per the National Immunization Schedule at the time of seeking admission to The Premia Academy. Please indicate the date of the Immunization of the child against each.

		Recommended age of immunization	Date
1	BCV & OPV-0dose (for institutional deliveries)	At birth	
2	BCG (if not given at birth)	At 6 weeks 3 months	
3	DPT-1 & OPV-1	At 6 weeks	
4	DPT-2 & OPV-2	At 10 weeks	
5	DPT-3 & OPV-3	At 14 weeks	
6	Measles	At 9 months	
7	DPT & OPV	At 16-24 months	
8	DT	At 5-6 years	
9	TT (Boosters)	At 10 & 16 years	

## Other recommended vaccinations

1	Hepatitis B Vaccine	3 doses at birth, 6 weeks, and 6 to 9 months and a booster at 10 years	
2	MMR	At 15-18 months	
3	Typhoid Vaccine	A dose of Vi polysaccharide vaccine every three years starting at or after 2 years	
4	Haemophilus Influenza (HIB Vaccine)	2 doses, 1-2 months apart starting at 2 months; and booster at 15-18 months	
5	Varicella virus vaccine (chickenpox)	1 dose at 1-12 years, thereafter at 13 years or later 2 doses 6-10 weeks apart	
6	Hepatitis A vaccine	1 dose (720 units) from 1-18 years; from 19 years onwards a dose of (1440 units) followed by a booster dose at 6-12 months	
7	Meningococcal vaccine	1 dose given every 3 years	

## Optional Vaccinations

1	Rabies pneumococcal	Consult your pediatrician	
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Name of the Pediatrician \_\_\_\_\_

Signature of the Pediatrician \_\_\_\_\_

Registration No. \_\_\_\_\_

Address \_\_\_\_\_

Pediatrician's stamp

## (TO BE FILLED BY THE PARENTS)

Did your child have any of the following ailments in the past:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Measles       | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Typhoid           |
| <input type="checkbox"/> Rubella       | <input type="checkbox"/> Goiter /Thyroid Disease     | <input type="checkbox"/> Malaria           |
| <input type="checkbox"/> Chickenpox    | <input type="checkbox"/> Mumps                       | <input type="checkbox"/> Allergies         |
| <input type="checkbox"/> Jaundice      | <input type="checkbox"/> Eczema                      | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Tonsillitis   | <input type="checkbox"/> Rheumatic Fever             | <input type="checkbox"/> Meningitis        |
| <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Discharging Ears  |
| <input type="checkbox"/> Pleurisy      | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Heart Murmurs     |
| <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Bladder or Kidney Infection | <input type="checkbox"/> Kidney Stones     |

OTHER SPECIFIC SYSTEMIC ILLNESSES (if any): (Please explain)\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does your child take any medication regularly ?\_\_\_\_\_

\_\_\_\_\_

Any other relevant information:

Please check if any relative (parents, siblings, grandparents) have had any of the conditions listed below:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Bleeding Tendencies |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric illness | <input type="checkbox"/> Seizures / Epilepsy |
| <input type="checkbox"/> Obesity       | <input type="checkbox"/> Diabetes mellitus   |  |

Parents Signature \_\_\_\_\_

Date \_\_\_\_/ \_\_\_\_/ \_\_\_\_

## FOOD ALLERGY/SEVERE ALLERGY INFORMATION

To ensure the safety of your child at school, The Premia Academy is requesting that you complete the following Food Allergy/Severe Food Allergy Information.

This form allows you to disclose whether your child has a food allergy or severe food allergies that you believe should be disclosed to the School, in order to enable school personnel to take necessary precautions for your child's safety.

Severe food allergy means a dangerous or life-threatening reaction of the human body to a food-borne allergen introduced by inhalation, ingestion or skin contact that requires immediate medical attention.

Please list any foods to which your child is allergic or severely allergic, as well as the nature of your child's allergic reaction to the food and treatment.

IF YOUR CHILD DOES NOT HAVE A FOOD ALLERGY/SEVERE FOOD ALLERGY PLEASE INDICATE NO ALLERGY AND RETURN THE FORM SIGNED AND DATED.

☐ No Allergy

Food	Nature of allergic reaction to the food:	Treatment

The Premia Academy will maintain the confidentiality of the information provided above and may disclose the information to teachers, and other appropriate school personnel.

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Parent/Guardian Name \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date Signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Office Use Only

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Staff Notified \_\_\_\_\_

Name(s) \_\_\_\_\_

# PARTICIPATION IN SPORTS AND SCHOOL ACTIVITY QUESTIONNAIRE



THE  
PREMIA  
ACADEMY

Name of Student \_\_\_\_\_ Grade \_\_\_\_\_

## Has the student:

Yes No

Been taking any medication?

☐☐

If yes, explain \_\_\_\_\_

Ever been diagnosed with asthma?

☐☐

If yes, explain \_\_\_\_\_

Ever been prescribed any asthma medication?

☐☐

If yes, explain \_\_\_\_\_

Ever fainted during or after exercise/activities?

☐☐

If yes, explain \_\_\_\_\_

Ever been dizzy during or after exercise?

☐☐

If yes, explain \_\_\_\_\_

Ever had chest pain during or after exercise?

☐☐

If yes, explain \_\_\_\_\_

Ever had racing of their heart or skipped heartbeats?

☐☐

If yes, explain \_\_\_\_\_

Ever had high blood pressure or high Cholesterol?

☐☐

If yes, explain \_\_\_\_\_

Ever told they had a heart murmur?

☐☐

If yes, explain \_\_\_\_\_

Ever had a head injury or concussion?

☐☐

If yes, explain \_\_\_\_\_

Ever been knocked out or become Unconscious?

☐☐

If yes, explain \_\_\_\_\_

Ever lost their memory?

☐☐

If yes, explain \_\_\_\_\_

Ever had a seizure?

☐☐

If yes, explain \_\_\_\_\_

Ever had numbness or tingling in their arms,  
hands, legs or feet?

☐☐

If yes, explain \_\_\_\_\_

Does the student :

Yes

No

Wear glasses or contact lenses?

☐☐

If yes, explain \_\_\_\_\_

Have any known deformities?

☐☐

If yes, explain \_\_\_\_\_

Tire quickly during exercise/activities?

☐☐

If yes, explain \_\_\_\_\_

Have frequent or severe headaches?

☐☐

If yes, explain \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## CONSENT FORM

I agree to let my child participate in all activities arranged by The Premia Academy including school events, field trips, and annual camps, etc. organized by the school. I realize that such events are an integral part of holistic education.

I agree to pay the school the charges specified for such participation.

I understand that such activities, expeditions, trips, camps, etc. will be supervised by the members of the school staff and that all reasonable safety precautions will be followed. I will not hold the school responsible for any circumstances beyond its control.

Place \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Name in Capitals \_\_\_\_\_