

TIMARU BOYS' HIGH SCHOOL - MEDICAL FORM

Name:

Home Address:

..... Date of Birth:

MEDICAL HISTORY Has he suffered any of the following? (answer Yes or No)

Mumps: German Measles:..... Chicken Pox:.....

Rheumatic Fever: Whooping Cough: Scarlet: Fever:.....

Or any other medical or surgical condition(including eye troubles, bed wetting, fits or epilepsy in any form, ear troubles, allergic states (such as hay fever, asthma or eczema), drug sensitivity, or any operations?

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FAMILY HISTORY: Is there any feature which might have a bearing on his health?

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INOCULATIONS:

Has he been inoculated against the following (please give the date of the last injections)?

Diphtheria: Poliomyelitis

Whooping Cough: Tuberculosis.....

Tetanus (Toxoid):..... Other?:.....

Meningococcal B.....

Do you give permission for maintenance of immunity against tetanus whilst he is at school?

Yes / No

ACTIVITY: Is he fit for all normal school activity and games? Yes / No

FAMILY DOCTOR'S REPORT:

This is not necessary unless special information is required to be given

1. Name of Family Doctor

2. Report enclosed Yes / No

I confirm that the above information is correct.

Signed: Date