CAIRO AMERICAN COLLEGE

Parent Form
To be completed every year

Health Office

Annual Student Information 2017-2018

Name:_____ Sex: M F
Last First Middle
Birth date:_____ Grade: _____

Guardian's Names/ Mother: _____ Father: _____
Cairo Address:_____ Home Phone: _____
Mother's Work Phone: _____Father's Work Phone: _____
Mother's Mobile: _____ Father's Mobile: _____

LOCAL CONTACT PERSONS
(If Parents are Unavailable)

Name: _____Phone_____

LOCAL EMERGENCY /MEDICAL CARE

Affiliated Health Unit:_____ Phone:_____
Pediatrician/Family Doctor: _____ Phone:_____
Preferred Hospital: _____ Phone:_____

MEDICAL HISTORY

Allergies: _____
Current Medications: _____
Does your child need an epipen for severe allergic reactions? Yes_____No_____

	Yes	No		Yes	No
Eye/ear problems			Abdominal complaints		
Neurologic problems			Kidney or urinary problems		
Heart Problems			Skin problems		
Lung Problems-including asthma			Hospitalization		
Tuberculosis			Fractures		

Please explain if any above were answered yes:

_____
_____
_____

AUTHORIZATION: valid from August until the following September.

(Please Circle Yes or No)

Permission to give non-prescriptive medications: (e.g. acetaminophen/antacid, etc.) _ Yes No
Permission to administer first aid: _____ Yes No
Permission to admit to hospital in extreme emergency: _____ Yes No

Parent's Signature: _____ Date: _____