Telfair International Primary School
ENGLISH MEDIUM
Morcellement Saltpans
Tamarin
Tel: (230) 4838108
Fax: (230) 4835108
E Mail: telfairprimary@orange.mu

To a valiant heart, nothing is impossible

Confidential Pupil Record

(2016)

Details of Pupil

Surname of Child: _____Age: _____

First Names: _____

Sex ___ Date of Birth: _____ Country of Birth: _____

Emergency Contacts: (If parents are unavailable)

1) Name: _____
   Tel: (Office) _____ (home) _____
   Relationship to Child: _____
2) Name: _____
   Tel: (Office) _____ (home) _____
   Relationship to Child: _____

Family History of Child:

Any other children in the family:

Name:	Age:
_____	_____
_____	_____
_____	_____
_____	_____

Is the family unit complete? (Please state whether parents are separated, divorced or widowed?)

_____

_____

Medical Record:

Were there any difficulties during the birth of your child?

Yes/No If yes, please give details. _____

_____

Has your child had any illnesses of a serious nature?

Yes/No If yes, please give details. _____

_____

Has your child had any major operations?

Yes/No If yes, please give details. _____

_____

Are all your child's vaccinations up-to-date?

BCG (Anti Tuberculosis) Yes/No

DPT (Diphtheria, pertussis and tetanus) Yes/No

OPV (Oral Poliovirus vaccine) Yes/No

MMR (Measles, mumps and rubella) Yes/No

Hepatitis B Yes/No

Meningitis Yes/No

Does your child wear glasses? Yes/No

If yes, for what purpose? _____

Does your child have any visual problems? Yes/No

If yes, what is the nature of the problem?_____

_____

Is your child colour blind? Yes/No

Has your child ever had an eye test? Yes/No

If yes, when was the test taken? _____

Does your child have a hearing problem? Yes/No

If yes, what is the nature of the problem?

_____

Has he/she ever had a hearing test? Yes/No

If yes, when was the test taken?_____

Does your child have any speech problems? Yes/No

If yes, what is the nature of the problem?

_____

Has your child ever had speech therapy? Yes/No
If yes, give details. _____

Does your child have any dental problems? Yes/ No
If yes, what is the nature of the problems?

_____

When did your child last see a dentist? _____
Does your child have any allergies? Yes, No
If yes, please indicate what your child is allergic to:

_____

_____

_____

Is your child asthmatic? Yes/No
Is it necessary for him/her to keep an asthma pump present at all times? Yes/No
Is your child on any strong medication? Yes/No
If yes, what medication and for what reason?

_____

Has your child ever been on Ritalin or any other similar medication? Yes/No
If yes, please give details.

_____

_____

Has your child ever had occupational therapy? Yes/No
If yes, please give details:

_____

_____

Does your child have any nervous fears or phobias? Yes/No
If yes, please give details.

_____

_____

Other Information:

Are there any circumstances that may affect your child's performance at school? (e.g. Does one parent live or work away from home? Has the family moved recently? Has there been a divorce or death in the family?)

_____

_____

_____

_____

Name of Family Doctor: _____
Address: _____
Tel: _____

Do you have any school reports, medical reports, psychological reports which would be useful for the school to keep copies of? Yes/No
The school already has them Yes/No

ALL INFORMATION SHARED ON THIS FORM WILL BE TREATED WITH THE GREATEST RESPECT AND IN THE STRICTEST CONFIDENCE.

Parent's signature: _____
Date: _____

Care at School:

Kindly remember when sending any medication to school, make sure that:

- Your child's **name** is clearly written on the medication
- The **dosage** is written clearly in the message book
- The **times** are written clearly in the message book

Please keep your child **at home**, if he/she has anything contagious. If your child comes to school with anything contagious, we shall have no alternative, but to contact parents to collect their child as soon as possible from school.

We do regular checks for head lice at school. **This is highly contagious.** Please do all the necessary treatment before sending your child back to school.

Please tick the relevant box regarding the administration of medication:

□ Clean wound using disinfectant and apply a plaster if necessary
□ Use ice and arnica on bump
□ Put soothing gel onto insect bites
□ Give paracetamol or an anti-inflammatory medication to my child for fever and pain
□ Give Actapulgite to my child if he/she develops diarrhoea at school
□ Give Primperan to my child if he/she develops vomiting at school

If your child is in need of urgent medical help at school, the school will contact the parents to inform them.
If parents cannot be contacted immediately, your child will be taken by a member of staff to a doctor or private clinic to be treated.

I authorise Telfair International Primary School to administer the following care in case my child falls ill or is injured at school and I cannot be reached by phone.

Signature: _____ Date: _____

Name of Parent: _____