JOFAY HIGH SCHOOL

MEDICAL FORM TO BE COMPLETED BY ALL STUDENTS

1. DOES YOUR CHILD SUFFER FROM ANY MEDICAL CONDITION SUCH AS ASTHMA E.T.C

   ____

   ____

2. IS YOUR CHILD ALLERGIC TO ANY MEDICATION?

   ____

   ____

3. NEXT OF KIN TO BE CONTACTED IN CASE OF EMERGENCY ____________

   ________ RELATIONSHIP ________ TEL NO: ______________

4. CAN YOUR CHILD BE TAKEN TO THE HOSPITAL IN ANY EMERGENCY SITUATION?

   YES ________ NO __________

5. WILL YOU BE RESPONSIBLE FOR ALL SUCH MEDICAL BILLS ACCRUED AT THE HOSPITAL?

   YES ________ NO ________

(PLEASE THIS PART IS TO BE FILLED BY THE MEDICAL PRACTITIONER AT THE LAB)

1. BLOOD GROUP OF STUDENT ______________
2. GENOTYPE OF STUDENT ______________

____

SIGNED & STAMPED (LABORATORY)