

FUNDAÇÃO ANGLO BRASILEIRA DE EDUCAÇÃO E CULTURA DE SÃO PAULO

ESCOLA BRITÂNICA DE SÃO PAULO

Rua Juquiá, 166 – Jardim Paulistano – CEP 01440-903 – São Paulo – SP – Brasil

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EMERGENCY MEDICAL INFORMATION

Please return this form to the School Secretary

FULL NAME OF CHILD:		DATE OF BIRTH		YEAR GROUP	
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FULL NAMES OF PARENTS / GUARDIAN

1. _____ Work Phone: _____ Home Phone: _____ Mobile Phone: _____

2. _____ Work Phone: _____ Home Phone: _____ Mobile Phone: _____

CHILD'S DOCTOR

OFFICE PHONE

PLEASE SPECIFY IF APPLICABLE

Dietary Restrictions:

DENTIST

OFFICE PHONE

Medications:

EYE DOCTOR

OFFICE PHONE

Allergies:

ADULT TO BE CONTACTED IN AN EMERGENCY IF PARENT CANNOT BE REACHED

1. Name & Relationship _____ Day time phone: _____

2. Name & Relationship _____ Day time phone: _____

MEDICAL INSURANCE

Asthma:

Insurance Company Name and Insurance Number: _____

In case of medical emergency at any time whilst my child is a pupil at St. Paul's School, I understand every effort will be made to contact me. In the event that I cannot be reached, I give permission to the physician selected by the School to send my child as named on this medical form to hospital to secure proper treatment. I agree to release the School and physician from any liability arising from such treatment.

Parent /Guardian signature _____

NON PRESCRIPTION RELEASE FORM

Please take note of the following rules for the use of medication in School:

1. If parents wish to have the support of the School in giving any medicine, a written request should be given to the School's Infirmary. Under no circumstance can a teacher assume responsibility for giving any medicine or for forwarding the request to the Infirmary on the parents' behalf. Pre-Prep and Prep aged children are not allowed to hand-in their medication to the infirmary - this must be done by their parent or legal guardian.
2. The School will only administer prescription medicines when in possession of a written note from the pupil/student's parent or legal guardian. This should include:
 - A. Pupil/Student's name;
 - B. Name of the medicine;
 - C. Unit dosage and time of administration;
 - D. Length of treatment;
 - E. Name and phone number of the physician;
 - F. Copy of the prescription containing the physician's signature and their CRM;
3. If the product is to be used on an on-going basis, then authorisations must be renewed every 3 months.
4. The School will offer outpatient primary nursing care to pupils and students and administer non-prescription medication so long as steps A-D are provided along with the medicine.

IN THE EVENT OF AN EMERGENCY

In case of serious accident or emergency your child will be taken to **HOSPITAL SAMARITANO** unless otherwise stated below:

I, _____, wish my child to go to _____ Hospital.

Parent / Guardian signature _____ Date ____/____/____

The information on this form is entered into our school database (called SchoolBase online). Parents are given an access code and password to check this medical information online. It is the responsibility of parents to keep this information up-to-date.