GRANT HOUSE - BOARDERS' MEDICAL RECORD

Surname :	
First Names:	ADMIN NO.:
Date of Birth:	BLOOD GROUP:

FATHER'S CONTACT DETAILS

Home:	Office:	Cell:
Home:	Office:	Cell:

MOTHER'S CONTACT DETAILS

Home:	Office:	Cell:
Home:	Office:	Cell:

HOME ADDRESS:

MEDICAL AID DETAILS

Name of Medical Aid:
MEMBERSHIP NO.:

NAME & I.D. NUMBER OF MAIN MEMBER OF MEDICAL AID

Name:	I.D.

DOCTOR IN GRAHAMSTOWN

Name of Doctor:	Tel:

DENTIST IN GRAHAMSTOWN

Name of Dentist:	Tel:

N.B. Parents are encouraged to open an account at **Wallace's Pharmacy** in Grahamstown. Your son will NOT have access to specialized medication without a pharmacy account. The staff of Grant House cannot be held liable for the cost of medication. PLEASE ATTACH A COPY OF YOUR MEDICAL AID CARD & ID OF THE MAIN MEMBER TO THIS FORM.

PHARMACY IN GRAHAMSTOWN

Pharmacy Name:	Tel.:
Account Name:	Acc Number:

MEDICAL HISTORY

Allergies:
Previous Illnesses:
Previous Operations:

Immunizations (please tick):	Injections:
Diptheria	Chicken Pox
Whooping Cough	Measles
Tetanus	Rubella
Polio	Whooping Cough
M.M.R.	Mumps
B.C.G.	Scarlet Fever