2011 CENTRE FOR ACADEMIC TALENT
MEDICAL FORM

Must be returned by 15th April 2011

Return to: **CENTRE FOR ACADEMIC TALENT**
The Irish Centre for Talented Youth
Dublin City University
Dublin 9

Part 1: This section should be filled in by parent or legal guardian. Please type or print plainly.

Student's Name: ____
Lastname Firstname M.I.

Home Address: ____

Date of Birth: _____/______/________ Gender Male [ ] Female [ ]
dd mm yyyy

Parent or Guardian's Name: ______________________________ (Father) ________________
Lastname Firstname Mobile telephone

Parent or Guardian's Name: ______________________________ (Mother) ________________
Lastname Firstname Mobile telephone

Home telephone: __________________________

Occupation: ______________________ (father) Work Tel: ______________________ email____________________________

Occupation: ______________________ (mother) Work Tel: ______________________ email____________________________

Who is the custodial parent of student: ❑ Both ❑ Mother ❑ Father ❑ Other _______________________________

Name of Medical Insurance Co. Medical Insurance No	or	Medical Card No.

If Parent not available in Emergency Contact: ______________________________ ______________________
Lastname Firstname Mobile Telephone

Relationship to Student: ____________________________________

Parents: **Please read and affix signature and date:**

This is to authorise the staff of the summer session site and/or emergency physicians (and any consultants that they deem necessary) of nearby (or the most appropriate) hospital to render necessary first aid/medical care to my child (name of child) ______________________________.

However, in the event of an emergency, if I cannot be reached, or the person designated above cannot be reached, I consent for the Health Centre staff of the summer session site, physicians on the active staff of the nearby (or the most appropriate) hospital, or another physician or hospital (as the case may be) to perform any emergency treatment including surgery, requiring the use of local or general anaesthetic. This authorisation shall be in effect as long as my child is a student in the CAT 2011 Summer Programme. Furthermore, I the undersigned will assume full responsibility for all medical costs incurred by my child not covered by medical insurance or normally provided without charge by the Health Centre of the summer session site as part of the 2011 CAT Summer Programme.

__________________________________ ______________________________
Signature of Parent or Legal Guardian Date

(Please Turn over)

STUDENT'S NAME: ____

MEDICAL HISTORY: Tick all applicable items:

Congenital Defects	Rheumatic Fever	Drug Allergy	Food Allergy
Frequent Sore Throats	Musculoskeletal Defects	Asthma	Eating Disorders
Sinusitis	Central Nerv. System Defects	Hay Fever	Emotional Problems
Frequent Ear Infections	Convulsions	Hives	Depression
Hearing Defects	Fainting	Eczema	Anxiety
Bronchitis	Migraines/headaches	Mononucleosis	Dyslexia
Pneumonia	Enuresis	Chickenpox	Dyspraxia
Serious Eye Defects	Urinary Tract Defects	Measles	Dyscalculia
Glasses	Serious Operations	German Measles	ADD or ADHD
Gastrointestinal Defects	Tuberculosis	Mumps	Asperger's Syndrome
Heart Defects	Diabetes	Insect Bite Allergy	

If there are any details of the items from the above checklist that a person acting in loco parentis or a person involved in the student's care or treatment should be made aware of, please include them below.

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Is your child under the care of a psychologist, psychiatrist, or counsellor? If so please provide name: ______________________________

Has your child received treatment for behaviour issues? Please include details below.

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If there are any physical activities in which you would not wish the student to participate, please indicate these below (include reasons)

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Any student taking medication during the Programme (even if self-administering) MUST be brought to the attention of the CTYI/CAT Director.

Please note CTYI/CAT will not be held responsible for non-disclosure of any medical condition.

TREATMENT - Give full details of any medical treatment, prescribed by any doctor, to be administered during the Semester.

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DOCTOR: Name: ________________________________ Telephone: ____________________

Address: ____

STUDENT'S NAME: ____

CTYI/CAT will supply the following medications (or their generic equivalents) as needed for the symptoms indicated, and according to package directions. Tick off those medications that your child can receive on an as-needed basis.

❑ Paracetamol/Neurofen for menstrual cramps, pain or headache	❑ Benelyn for cough	❑ Optrex/Brolene for eye irritation
❑ Imodium/Arret for diarrhoea	❑ Strepsils throat lozenges for sore throat	❑ Lemsips/Beechams hot lemon for colds
❑ Rennies/Motillium for stomach upset	❑ Sudafed for sinus congestion	❑ Waspeze/Anthisan for stings and bites
❑ Piriton/clariton/benadryl/Zyrtec for allergy symptoms		

Does your child carry an EpiPen for Allergies? ❑ Yes ❑ No

Allergies to medications, food, insect bites, environmental factors etc:

Special Dietary Needs

❑ Vegetarian
❑ Vegan
❑ Coeliac
❑ Other: please indicate: ____________________

Medical Expenses Authorisation

Families are responsible for the costs of prescriptions and transport costs to and from medical centres and any health care beyond that provided free of charge on campus. Please note that these costs must be paid for immediately. Please provide a credit card / laser card number that will allow CTYI/CAT to charge you for these expenses. Please note that CTYI/CAT will contact you prior to charging this card. If you do not have a credit card CTY/CATI will contact you before any basic medical treatment.

Please charge my ❑ Visa ❑ MasterCard ❑ Laser

Name of Card Holder: ____
(Please print)

Card account Number: ______________ - ______________ - ______________ - ________________

Card expiry Date: ________________________________

Signature of Cardholder ________________________________ Date: ____________________