Stimulation Centre for Children with Severe Disabilities
25A Bernard Street, Poortview - Tel: 078 571 9096 - Reg No. 034-468 NPO
www.pathwaysroodepoort.org.za / sunette@pathwaysroodepoort.org.za

Medical Information

Date: _____

Full Names (child)	
D.O.B	
Gender	
Diagnoses	
Allergies	
Medical Aid Scheme	
Membership No	
Name of Doctor	
Doctor Tel No	

Is your child taking medication

Yes		No	

If applicable: Do you agree that Pathways staff may administer the medication? Have you ensured that they are competent to do so? If you perceive any risk please mark "No".

Yes		No	

Please state medication*

Morning	
Midday	
Evening	

Parent / Guardian Details

Full Names	
ID Number	
Contact Number	
Email Address	

Parent / Guardian Details

Full Names	
ID Number	
Contact Number	
Email Address	

Caregiver appointed by Parent / Guardian

Full Names	
ID Number	
Contact Number	
Email Address	

In the event of an emergency we authorise the Centre or the responsible staff member to employ the services of an emergency service, medical doctor, hospital or other comptent person. Any cost for such service will be carried by the signatory/s.

Because medicine dosages are adapted/changed for your child it is your responsibility to ensure that we have the latest information on record.

Signature _____ Print name in full _____ (Father)

Signature _____ Print name in full _____ (Mother)

Signature _____ Print name in full _____ (Witness)