

STUDENT MEDICAL FORM FOR AY 2010/2011 (English)

Student Name:	Date of Birth:
Parent/Guardian Name:	
Address:	Tel. No:
Tel. No.:(Mother's Business):	Mobile:
Tel. No.:(Father's Business):	Mobile:
Emergency Contact Name and Tel. No.:	
Medical Insurance Company:	Policy Number:

In order to keep an up to date medical record of your child, it would be much appreciated if you would answer the following questions. Does your child suffer from any of the following conditions?

	Yes	No	Does any other member of the family?
Allergies (if yes, please state to what?)			
Asthma			
Diabetes			
Epilepsy			
Eczema			
Hay Fever			
Heart Disorders			
Hearing Difficulties			
Speech Impediment			
Sight problems			

Please check and give dates of previous illnesses and immunisations.

Illness	Yes	No	Immunisation	Month/Year	Month/Year	Month/Year
Chickenpox			Polio			
Diphtheria			Diphtheria			
German Measles			Tetanus			
Measles			Pertussis (Whooping Cough)			
Mumps			Measles			
Polio			Mumps			
Rheumatic Fever			Rubella (German Measles)			
Scarlet Fever			Tetanus Booser			
Frequent colds			Tuberculin Tests			
Ear Infections			Hepatitis B			
Operations			Hib (Haemophilus influenzae B)			

Does the school have permission to give your child non-prescription medication, including Aspirin/Tylenol? YES / NO

Does the school have your permission to take your child to the nearest hospital in case of emergency? YES / NO

Is the student currently on medication? YES / NO

If yes, please give details: _____

Is there any reason for your child to have restricted physical activity, including swimming? YES / NO

If yes, please explain: _____

Should your child wear eye glasses? YES / NO

Signature of parents / guardians _____ Date _____ / _____ / _____
Day Month Year

