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MEDICAL FORM

STUDENT'S INFORMATION

Child's Name: _____
First Name Middle Name Last

Date of Birth: _____ Age: _____ Gender: M F

Address: _____

Class Applied For: _____

CONTACT INFORMATION

In case of emergency school authorities should contact

1) Name: _____ Telephone: _____

2) Name: _____ Telephone: _____

HEALTH INFORMATION

Height: _____

Weight _____



IMMUNIZATION HISTORY:

All students must have completed their minimum vaccination requirements, at the time of seeking admission. Please indicate the date of immunization in the space given below and provide a Photocopy of the Vaccination Card.

RECORD OF IMMUNISATION

	Primay(dd/mm/year)	Booster(dd/mm/year)		Primay(dd/mm/year)	Booster(dd/mm/year)
BCG			Illness		
Polio			Malaria		
DPT/DTap			Tuberculosis		
MMR			Diabetes		
Cholera			Rheumatic fever		
Typhoid			Epilepsy		
Hepatitis A			Allergies		
Hepatitis B			Hepatitis A or B		
Measles			Chicken pox		
Chicken Pox			Measels		
Record of Illness			Mumps		

- 1) Has your child gone under any operation? If yes give details _____
- 2) Does your child take any medicine for chronic ailments? If yes mention the name _____
- 3) Student is allergic to (If any specify) _____
- 4) Blood Group _____
- 5) Skin problems if any _____
- 6) Eyes: does he/she have normal vision? If no provide details: Yes No _____
- 7) ENT examination _____
- 8) Dental condition _____
- 9) Immunization status _____
- 10) Is student receiving any long term medication? If so please specify _____

Special instruction for school to note: _____

I/We give my/ our consent for emergency measures to be taken by the school Doctor, Nurses or / and Authorities if and when the need arises.

Parent / Guardian Name:

Parent / Guardian Sign:

(Please note that the above information is required in order to provide the best medical care to your child, Your kind cooperation is solicited)