Medical Form

Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child suffer from one or more of the following? If so, please give details:

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO | Please give Details |
| Chest Asthma |  |  |  |
| Food Allergies |  |  |  |
| Drug Allergies |  |  |  |
| Epilepsy |  |  |  |
| Skin Problems |  |  |  |
| Urinary Disorder |  |  |  |
| Scoliosis |  |  |  |
| Phobias |  |  |  |
| Tuberculosis |  |  |  |
| Heart Disease |  |  |  |
| Hearing Problems |  |  |  |
| Headaches |  |  |  |
| G6PD |  |  |  |
| Diabetes |  |  |  |
| Past History of Surgery |  |  |  |
| Convulsions due to high Fever |  |  |  |
| Thyroid Problem |  |  |  |
| Epistaxis (Nose Bleeding) |  |  |  |
| Hay Fever (Pollen) |  |  |  |
| Bees Allergy |  |  |  |
| Other |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Has Your child been inoculated against: | YES | NO | Date |
| Polio |  |  |  |
| Cholera |  |  |  |
| Tetanus |  |  |  |
| Yellow Fever |  |  |  |
| Typhoid |  |  |  |
| Whooping Cough |  |  |  |
| Measles |  |  |  |
| Other |  |  |  |

Is your child taking any specific medication on a regular basis? If so, please give details (Name, Dosage and Reason/s)? YES NO

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