Child's Picture

STUDENT MEDICAL REPORT

CHILD'S NAME _____

DATE OF BIRTH _____

SEX : _____ **COUNTRY OF BIRTH :** _____

Name & Tel. No. of Doctor _____

Blood Group _____

Has your child contracted any of the following illnesses?
If 'YES' please give approximate date.

ILNESS	YES / NO	DATE	ILNESS	YES / NO	DATE
MEASLES			MUMPS		
WHOOPING COUGH			GERMAN MEASLES		
CHICKEN POX			SCARLET FEVER		

If your answer is 'Yes' to any of the following questions then please give a brief explanation in the space provided.

Does your child suffer from any other medical conditions (e.g. Diabetes, Epilepsy)?

YES		NO	

Does your child wear glasses?

YES		NO

STUDENT HEALTH QUESTIONAIRE

FULL NAME _____DATE OF BIRTH _____

SEX _____ COUNTRY OF BIRTH _____

If you answer "yes" to any of the following questions, please give an explanation:
Has your child suffered or currently has problems in any of the following:

ALLERGIES	
BEHAVIOURAL PROBLEMS	
VISION/EYESIGHT	
HEARING	
SKIN CONDITIONS	
RESPIRATORY CONDITIONS	
DIGESTIVE CONDITIONS	
CARDIAC CONDITIONS	
TONSILS/ADENOIDIS	
URINARY CONDITIONS	
BONE/JOINT CONDITIONS	
SEIZURES/EPILEPSY	
BLOOD DISORDERS	

DIABETES	
SPEECH DIFFICULTIES	
HEADACHES	
SIGNIFICANT PAST ILLNESS, INJURES OR OPERATIONS	
SPECIAL DIETARY REQUIREMENTS	
REGULAR MEDICATION (Please Specify)	

	YES	NO
Has your child received all required vaccinations		

I agree to my child taking part in the school Health Screening Programme.

YES **NO**

Signature of Parent: _____ Date: _____