

STUDENT MEDICAL FORM

(To be completed by Parent / Guardian)



Student Details

Student's Name: **Grade:**
Sex: F M **Date of Birth:** DD MM YYYY **Blood Group:**
Day Scholar **Weekly Boarder** **Regular Boarder** **Nationality:**
Family Doctor: **Medical Insurance No.:**

Contact Details

Father's Name:
Phone No.: Home Work
Mobile **Email:**
Mother's Name:
Phone No.: Home Work
Mobile **Email:**
Present Home address:
.....
.....

A) Food & Personal Habits

My child is: Vegetarian Non- Vegetarian

B) My child suffers from

Asthma	Diabetes	Bronchitis	Kidney Problem
Ear-ache	Sensitive Skin	Sleepwalking	Nosebleed
Fainting	Sinus Trouble	Convulsions	High Blood Pressure
Tonsillitis	Frequent Colds	Headache	Motion Sickness
Eye Infection	Nightmares	Bed Wetting	

If any other, please specify:

C) Allergies

My child has an allergy to (Please specify)

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D) Immunisations

My Child's immunization shots are current.

Typhoid Polio Vaccine Tetanus Small Pox Diphtheria

Others (Please specify)

E) Vision

My child wears glasses: YES NO

My Child wears contact lenses: YES NO

My child is: Short sighted Far sighted

F) Medication

I would like my child to be given,

Name of Medication(s)

Purpose of Medication (s)

G) Surgeries/Operations

Has your child undergone any operation / surgery / been admitted to any hospital?

YES NO

Please mention the date, reason and duration that your child was in hospital?

Date: Duration:

Reason:

G) Other Information

If there is any other information you would like to share with us, please mention it in the space below:

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In case of any emergency, I hereby give permission to the school to provide the necessary medical attention for my child.

Parent/Guardian signature: Date: