INTERNATIONAL SCHOOL EERDE

PUPIL'S MEDICAL RECORD

Please have the following completed and returned to school before the enrolment of your child

Thank you for your cooperation. It is very important that an accurate reply be given to all sections.

Last Name:

____

First name(s):

____

Sex □ F □ M Date of birth: ______________ Blood group: ________

Medical insurance with: ______________________________________

Phone number in case of emergency:

____

Name/contact details of your child's family doctor:

____

____

I am the parent/guardian of the student named above. I give permission for the information on this form to be reviewed and utilised by the school's doctor, directors and any school personnel providing school health services, for the limited purpose of meeting my child's health and educational needs.

Place and date: ______________________________________

Signature (parent or guardian): ____________________________

Would you like to discuss any aspect of your child's health? □ YES □ NO

Does your child have special dietary requirements? □ YES □ NO

____

SECTION I - PUPIL'S MEDICAL HISTORY

Has he/she, or does he/she suffer (ed) from:

Any concerns about nutrition, eating habits, weight etc. □ YES □ NO

Diabetes (if yes, state type) □ YES □ NO

____

Any trouble with sleeping habits □ YES □ NO

Any allergies (food, insects, medication etc.) □ YES □ NO

Any orthopedic trouble □ YES □ NO

Any social, emotional or behavioural problem □ YES □ NO

Epilepsy □ YES □ NO

Any problem with vision, hearing or speech □ YES □ NO

Any heart trouble (heart murmur etc.) □ YES □ NO

Any significant accidents or injuries □ YES □ NO

Any recurrent illnesses (tonsillitis, headaches etc.) □ YES □ NO
Any lung problems/asthma □ YES □ NO
Any skin problems □ YES □ NO
Any concerns about kidneys or uro-genital system □ YES □ NO

Other: ____

If you answered 'yes' to any of the above, please provide details (nature and frequency of the trouble, last episode, intensity etc.) below:

____
____
____
____
____
____

SECTION II - PAST ILLNESSES Check the correct response, and give date if possible:

		DATE
Mumps	□ YES □ NO □ do not know	____________________
German measles	□ YES □ NO □ do not know	____________________
Other	□ YES □ NO □ do not know	____________________
Scarlet fever	□ YES □ NO □ do not know	____________________
Whooping cough	□ YES □ NO □ do not know	____________________
Chickenpox	□ YES □ NO □ do not know	____________________
Diphtheria	□ YES □ NO □ do not know	____________________
Measles	□ YES □ NO □ do not know	____________________
Pneumonia	□ YES □ NO □ do not know	____________________

Kindly attach copy of vaccination booklet

SECTION III - GENERAL ISSUES
Has the student ever spent time in hospital or undergone surgery? If so, give details.
□ YES □ NO

____
____

Does the student take medication regularly or occasionally? If so, which and for what reason?
□ YES □ NO

____
____

Is there any reason that the pupil may not participate fully in school activities, including physical education? If yes, give the reason, and the necessary restriction/adaptation:
□ YES □ NO

____
____

Does you child follow/has your child followed any psychological or psychiatric treatment? If so, please give details:
□ YES □ NO

____
____

SECTION IV – VACCINATIONS Please check the correct response and give date if possible:
(Please enclose a copy of vaccination record if available)

		DATE	
Hepatitis A + B Twinrix	□ YES □ NO	_______________	
Booster	□ YES □ NO	_______________	
Poliomyelitis	□ YES □ NO	_______________	
Type of vaccine:	_____________________________		
Hepatitis B	□ YES □ NO	_______________	
Diphtheria-	□ YES □ NO	_______________	(Tetanus-Whooping cough (Di-Te-Per))
Diphtheria-	□ YES □ NO	_______________	(Tetanus-Polio (Di-Te-Pol))
Tuberculosis BCG	□ YES □ NO	_______________	
Tuberculine test	□ YES □ NO	_______________	(Mantoux) □ successful □ unsuccessful
Tetanus	□ YES □ NO	_______________	
Hepatitis A	□ YES □ NO	_______________	

Other vaccinations ______________________________________
Type of vaccine ____

Serums (e.g. anti-tetanus) _______________________________
Type ____

Name of pupil:
____
- □ is in good health.
- □ has not been in recent contact with anyone suffering from a contagious disease.
- □ Should be under observation for the following:

____
Place and Date: ____
Family Doctor's stamp and signature _______________________

Once parents decide to sign this document themselves, parents are agreeing that all information is true and correct. Parents are to inform the school immediately if any details on this form subsequently change. International School Eerde cannot be held responsible for missing/incorrect information.