



MEDICAL FORM

The following information is requested so that the school and parent can work together to meet physical, intellectual and emotional needs of the child. Please fill out the information requested in Section A. Section B is to be completed by a physician or a health care provider. Section B1 may be certified by transcription of information from the certificate of immunization

SCHOOL HEALTH APPRAISAL

Personal details

Child's name _____
first *family*

Child's date of birth _____ Place _____

Home Address _____

Mother's name _____ phone no _____

Father's name _____ phone no _____

Contact person in case of emergency (please indicate name and phone number)

_____ phone no _____

SECTION A – HEALTH HISTORY

Is your child having any of the problems listed below?

	YES	NO
1. Allergies or reactions: (for example: food, medication, animals or other)		
2. Hay fever, asthma or wheezing		
3. Eczema or frequent skin rashes		
4. Convulsions / Seizures		
5. Heart trouble		
6. Diabetes		
7. Frequent colds, sore throats, earaches (4 or more per year)		
8. Trouble with passing urine or bowel movements		
9. Shortness of breath		
10. Speech problems		
11. Dental problems : date of last examination		
12. Other		

If you responded “yes” to any of the above, please make specific comments as to approximate dates of illnesses and specify any other chronic or recurring illnesses not on the list:

Does your child take any medication regularly? Yes No

If yes, what medication? _____

Reason for medication _____

Please mention any specific activities to be restricted (and reason) or any conditions that could affect your child’s learning or activities in school:

Do you suspect that your child has learning difficulties? Yes No

If yes, what are the symptoms?

Is your child diagnosed with special education needs? Yes No

If yes, please indicate the diagnoses and the treatment.

SECTION B – 1. IMMUNIZATIONS

VACCINE	DATE ADMINISTRATED			
	Type	day / mo / year	Type	day / mo / year
DTaP / DTP / TD (specify type)		1.		6.
		2.		7.
		3.		8.
		4.		9.
		5.		10.
Haemophilus influenzae type B (HIB)		1.		3.
		2.		4.
POLIO IPV / OPV (specify type)		1.		4.
		2.		5.
		3.		
MMR		1.		2.
Varicella (Chickenpox)		1.		2.
Hepatitis B HBV		1.		3.
		2.		
Pneumococcal Conjugate (PCV)		1.		3.
		2.		4.
Other Vaccines				
Indicate physician diagnosis or laboratory evidence of immunity as applicable				
Vaccines waived due to reactions/contraindications / religious objections				

2. Medical Examination: to be completed in full by a physician. It must be performed no earlier than six months before arrival at school. An examination for some other purpose within this period is acceptable. The examination is for determining fitness to engage in school activities.

Hgt Wt B.P. Hgb Urine

VisionEyes Ears Nose Throat

TeethHeart Lungs Abdomen

Extremities SpineMental status

Glasses (reading, distance, all times)Hearing aid
Braces (specify) Other corrective devices (specify).....
Regular medications (specify)
Skin (rashes, scars)
Physical restrictions
General appraisal
.....

RECOMANDATIONS

If there any defect of vision, hearing or other condition for which the school could help by seating or other action? Yes No

If yes, please explain:

Should the student’s activity be restricted because of any physical defect or illness? Yes No
If yes, check bellow and explain degree of restriction:

Classroom Playground PE lessons Swimming pool Other

I have examined the person herein described and have reviewed the health history on this form. It is my opinion that this person is physically able to engage in all school activities, except as noted above.

Physician’s name: _____

Stamp and signature _____

Date _____
