Health Record

Student Name _____**Grade**_____

Health Card Type& Number- e.g. Thiqa or Others_____

General Health Information

Has your child received all required vaccinations to date? Yes _____ No _____

If no, why? _____

Does your child have corrected vision? Yes _____ No _____

Does she/he wear eye glasses? _____ contact lens _____ both _____

Does your child suffer from hearing loss? Yes ____ No ____ if yes please specify _____

What is the date of her/his last dental examination? _____

Does your child have any allergies? Yes _____ No _____

If yes, please specify allergy _____

Medication for allergy _____Has been confirmed by doctor? Please give details_____

Does your child have any specific disease, e.g. **Diabetes, Heart disease, Kidney, Asthma, Epilepsy?**

Yes ____ No ____, if yes, please specify _____& **Provide medical report.**

Is she/he on **regular medication** for this? Yes _____ No _____ Name of medicine _____

Is the student suffering from **G6PD, Thalassemia, Sickle cell, Hemophilia**? Please specify _____

Does the student suffer from **recurrent nose bleeding**? _____

Does the Student have any **skin problems?** _____

Has the student had any **previous surgery?** Please specify_____

Has the student been **infected with mumps, measles, chicken pox, or other infectious /communicable diseases?**
Please specify _____

Does your child require a special diet? Yes ___ No ___, if yes, Please specify_____

Is there any medical reason to limit your child's participation in the school's sports program? Yes _____ No _____

If yes, please describe and send a medical report if applicable _____

Accident and Emergency

In case of accident or sudden illness, whom should the school contact first?

Name _____ Relationship? _____

Phone(s) _____ _____ _____

Preferred Doctor _____ Preferred Hospital _____ Phone _____

Consent for Treatment at the school clinic

This consent must be signed by a parent or legal guardian only

I give my consent to the school health staff to provide basic first aid and minor analgesics as needed and to administer the prescription drugs left by me in its care, according to their specified written instructions. I give permission to the school Authorities to take my child to the hospital in an emergency

Signature Relationship Date

Please notify the school promptly of any change in your daughter's/son's health status.