

Students International Limited

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Medical Form

Student's Name :

Date of Birth :

Height : Weight :

Infections

Has your son/daughter had any of the following infections ? If yes please specify at what age or the date affected.

Mumps :

Chicken Pox :

Whooping Cough :

Malaria :

Measles :

German Measles :

Scarlet Fever :

Diphtheria :

Rheumatic Fever :

Meningitis :

Inoculation

Has your son/daughter been inoculated against the following diseases? If yes, please specify the number of times that the child had the inoculation and the date of the last inoculation.

Diphtheria :

Whooping Cough :

Poliomyelitis :

MMR :

German Measles :

Rubella :

Mumps :

Tuberculosis BCG :

Hepatitis A :

Hepatitis B :

Others please state :

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Allergies

Does your son/daughter like domestic animals ? Yes/No

Are there any animals your son/daughter does not like or is allergic to ? Yes/No

If yes, please specify :

Is your son/daughter allergic to any food ? Yes/No

If yes, please specify :

Is your son/daughter allergic to any medicines ? Yes/No

If yes, please specify :

Does your son/daughter have any other allergies ? Yes/No

If yes, please specify :

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Medical Condition

Please give details if your son/daughter has any of the following

Eyesight problem :

Problems of teeth :

Ear infection, aural discharge, nose or throat conditions :

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Requires a special diet :

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Does your son/daughter suffer from any illnesses ? Yes/No

If yes, please specify :

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Does your son/daughter suffer from any mental illness ? Yes/No

If yes, please specify :

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Does your son/daughter take medication regularly ? Yes/No

If yes, please specify :

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Is your son/daughter having any ongoing treatment ? Yes/No

If yes, please specify :

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Medical Condition - Continued

Does your family have any inherited diseases ? Yes/No

If yes, please specify :

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Has your son/daughter had any surgical operations ? Yes/No

If yes, please specify :

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When was the last time your son/daughter visited a doctor ?.....

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Name and address of the family doctor :

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Signed : Date :