MEDICAL HISTORY

STUDENT FULL NAME | **[ ] MALE [ ] FEMALE** | **DATE OF BITRH (DD/MM/YY)** | **GRADE** | **TEACHER**

HOME ADDRESS | **HOME PHONE** | **EMERGENCY NAME, PHONE, ADDRESS**

FATHER'S FULL NAME | **ORGANISATION & ADDRESS** | **BUSINESS PHONE**

MOTHER'S FULL NAME | **ORGANISATION & ADDRESS** | **BUSINESS PHONE**

PAST ILLNESS: CHECK THOSE CHILD HAS HAD | **GIVE APPROXIMATE DATES** | **NOTE COMPLICATIONS**

ILLNESS	NO	YES DATE	COMPLICATION	ILLNESS	NO	YES DATE	COMPLICATION	ILLNESS	NO	YES DATE	COMPLICATION
CHICKEN POX				PNEUMONIA				SCARLET FEVER			
GERMAN MEASLES				TUBERCULOSIS				EPILEPSY			
MUMPS				ASTHMA				HEART TROUBLE			
MEASLES				CONVULSION				KIDNEY TROUBLE			
WHOOPING COUGH				POLIOMYELITIS				RHEUMATIC FEVER			
DIABETES				HAY FEVER				EMOTIONAL			
SPEECH PROBLEM				EYE TROUBLE				EAR TROUBLE			

PLEASE BRING A COPY OF YOUR IMMUNIZATION CARD

	O.P.T. & O.P.V.	B.C.G.	M.M.R.
1ST	_____	_____	_____
2ND	_____	_____	_____
3RD	_____	_____	_____

BOOSTERS

PROBLEM AREAS (PLEASE CLARIFY ANY AREAS CHECKED ABOVE THIS SPACE | **OPERATIONS/ INJURIES (DATE)** | **DOCTOR**

ALLERGIES (SPECIFY)

VACCINE _____

FOOD _____

MEDICATIONS _____

OTHERS _____

PERMISSION IS GRANTED FOR:

[ ] PANADOL

[ ] EMERGENCY CARE – FIRST AID

[ ] TREATMENT FOR INJURIES – FIRST AID

[ ] DISSEMINATION OF PERTINENT INFORMATION TO SCHOOL PERSONNEL FOR THE WELFARE OF THE STUDENT

SIGNATURE OF PARENT/ GUARDIAN

_____

DATE::