

HEALTH INFORMATION

Name: _____ Grade: _____

Date of Birth _____ (YYYY/MM/DD)

In case of Emergency, please provide the Name and Phone Number of Relative, Neighbour, Friend.

Name _____

Relationship to the child _____

Telephone _____ Mobile _____

E-mail: _____

Please check any of the following conditions which currently affect your child:

- Diabetes Kidney/Bladder Liver/Spleen Orthopaedic/bone
 Vision problem Heart problem Eye glasses Depression /stress
 Hearing problems Blood disorder Seizures
 Asthma Severe Mild Caused by _____
 Allergies to:

- Any medication _____
 (*Students requiring medication at school MUST have parent's written note)

Please check if your child has had any of the following diseases:

- Chicken Pox Hepatitis Polio Tonsillitis
 Diphtheria Malaria Tuberculosis Rheumatic Fever
 Scarlet Fever Typhoid Fever German Measles Mumps
 Smallpox Whooping Cough

History of Immunization

Type Vaccine	Date	Type Vaccine	Date
Tuberculosis-BCG		Polio	
MMR (Measles, Mumps, Rubella)		DPT (Diphtheria, Pertussis, Tetanus)	
Hepatitis B		Date of last X-Ray	

I will inform the school of any changes in the above information. I understand that if my child contracts an infectious disease or condition I will inform the school and withdraw my child until he/she is no longer infectious

Parent's signature: _____

Date: ____ / ____ / ____
Day Month Year