LA MAISONNETTE BILINGUAL PRESCHOOL (FRENCH AND ENGLISH)

MEDICAL FORM

Date:

Child's Details

1. Name of Student: _____
2. Gender: _____
3. D.O.B: _____
4. Age: _____
5. Mother's Tel No: _____ _____
6. Father's Tel No: _____ _____
7. In case of an emergency and if the school is unable to contact the parents
   Please notify:
   Name: _____ Tel No: _____

   Relationship to Child: _____ Business No: _____

Paediatric Details

1. Name of Practice: _____
2. Dr's : _____
3. Practice Address: _____
4. Tel No: _____

   _____

Immunizations

IMMUNIZATION	DATE	DATE	DATE
BCG			
Diphtheria Tetanus			
Pertussis Whooping Cough DTP DTaP DT, TD, DPT			
Poliomyelitis (OPV, IPV)			
Heamophilius Influenza type B HIB			
Hepatitis B Vaccine HBV			
Hepatitis A			
Measles			
Typhium V			
Measles, Mumps, Rubella (MMR)			
Varicella Vaccine			
Hx Chicken Pox			
Meningococcal			
Meningovax A+C			
Others:			

Additional Health Issues

No.	AILMENT		YES		NO		Please give details
1.	Heart Condition						
2.	Nervous disorder						
3.	Allergies: Penicillin, Sulfa Drugs, Serum, Foods						
4.	Blood Disorders						
5.	Special Diets						
6.	Childhood Diseases – Mumps, Chicken Pox						
7.	Skin Problems/Rashes						
8.	Sickle Cell Anaemia						
9.	Surgery of any type						
10.	Asthma, respiratory problems						
11.	Past Admission to Hospital						
12.	Prescribed medication for other concerns						
13.	Height (inches) :				Weight (Kg):		

14. Is there a condition in the family or medical problem in the family that the school should be aware of?

Yes No

If yes, please give details:

_____

_____

15. Is there any reason why the student should not participate in full Physical Education Programme?

Yes No

If yes, please give details:

_____

_____

16. Are there any other concerns you would like us to include?

_____

17. I hereby give permission to the School Authority to act in Loco Parentis in emergencies and accept that all medical bills incurred be forwarded to me. I also authorise the school to take my child to their allocated hospital should an emergency arise and the location of our current hospital not be in close proximity.

_____ _____

Signature of Parents Date