



MEDICAL FORM

Name of the student: _____ Yes___ No___

Has your child received the necessary vaccinations? Yes___ No___

Does your child wear eyeglasses? Yes___ No___

Does your child suffer from hearing difficulties? Yes___ No___

If yes, explain _____

Does your child have any blood disease or diabetes? Yes___ No___

If yes, explain _____

Does your child suffer from any breathing problem Yes___ No___

or Asthma? If yes, explain _____

Does your child have any allergies? Yes___ No___

If yes, explain _____

Is your child on any form of medication? Yes___ No___

If yes, explain _____

Is your child on a special diet? Yes___ No___

If yes, explain _____

Is there any reason why your child should NOT participate in the school's sport's program? Yes___ No___

If yes, explain _____

Did your child undergo any surgery? Yes___ No___

If yes, explain _____

- Please sign below that you give permission for the school to administer the following **NON-PRESCRIPTION** medications when necessary:

- Antihistamines
- Cough Syrup
- Panadol & Anti-inflammatory Drugs
- Antibiotic Creams

Signature _____

Date _____

- Please sign below that you give permission for the school to transfer your child in case of emergency to closest medical center.

Signature _____

Date _____

Please return this form the next day to school. The original copy will be in your child's file and you will receive a copy.