STUDENT MEDICAL INFORMATION

JOHN F. KENNEDY INTERNATIONAL SCHOOL

Please print or type clearly.
The form must be completed carefully and signed by both a physician and a parent.

1. **Name of Student**: ____________________________________ **Sex:** ________________

   Date of Birth: ___________________ **Height**:__________**Weight:** _______________

2. Check and explain below if your child has **any problems** with:

Eyes	❑	Ears	❑	Nose	❑	Throat	❑
Lungs	❑	Heart	❑	Skin	❑	Glands	❑
Feet	❑	Stomach	❑	Intestines	❑	Nerves	❑

   Other ____

   Explanation: ____

   ____

   ____

3. Indicate **previous illnesses of child** with approximate dates (*day/month/year*):

   Measles__________________ Mumps__________________ Chicken Pox____________

   Whooping Cough___________ Rheumatic Fever__________ Tonsilitis_______________
   Bronchitis________________ Appendicitis______________ Asthma_________________

   Other: ____

4. Is there a **history of illness** in the child's immediate family (parents, grandparents, etc.)?

Tuberculosis	❑	Diabetes	❑	Heart Disease	❑
Anaemia	❑	Epilepsy	❑	Mental Illness	❑

   Other ____

   Explanation: ____

   ____

5. **Allergies and Sensitivities:** (Please check and explain below.)

Insect Bites	❑	Medication	❑	____________________________
Hayfever	❑	Food	❑	____________________________

   Other ____

6. Has your child been under prolonged medical or psychological care at any time? If so, please specify.

   ____

   ____

(see reverse)

7. Does your child require any **regular medication or other special measures** to be taken with regards to health?

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8. **A. Vaccinations**: Please give exact dates *(day/month/year)*.

Vaccine	**Date Given**	**Date Due**	**Vaccine**	**Date Given**	**Date Due**
Polio-Salk			Rubella		
Polio-Sabin			Mumps		
DTP			Tetanus		
Measles					

B. Laboratory Procedures: (Please give dates and results.).

Tuberculin Test: ____________________ Urinalysis: ____________________________

Chest X-ray: ____________________ Blood Test: ____________________________

Blood Pressure: ____________________ Blood Group: ____________________________

C. Check-ups: Please indicate the <u>last date</u> of the following *(day/month/year)*:

Dental Check-up: ____________________ Vision Test: ____________________

It is recommended that children visit the dentist every 6 months. Therefore, they should have their check-ups within three months of the beginning of the term.

9. **Physician's Analysis:**

On the basis of this child's history, physical examination and other data, the following statement is applicable: (please check)

( ) This child is in excellent health, and no significant abnormalities are noted.

( ) This child is in good health, but the following abnormalities should be noted:

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Date: ____________________ Signature of Physician: ____________________________

Name and Address of Physician ____

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10. **Declaration of Parent:**

Should my child be injured or become ill while attending the John F. Kennedy School, I expect the school authorities to see that he/she is attended to by qualified medical or dental practitioners, and I authorize the school to act on my behalf in arranging whatever treatment appears necessary, with the following exceptions:

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Date: ____________________ Signature of Parent: ______________________________