Student's medical questionnaire

John F. Kennedy International School, 8 Chilchgasse, 3792 Saanen, Switzerland.

Thank you for your cooperation. It is very important that a correct reply be given to all sections.

Name: _____

First name: _____

Sex F ☐ M ☐ Date of birth: _____ Blood group: _____

Contact person / Phone number in case of emergency: _____

Address _____

_____

I am the parent/guardian of the student named above. I give permission for the information of this form provided about my child to be reviewed and utilized by the doctors, directors and any school personnel providing school health services, for the limited purpose of meeting my child's health and educational needs.

Place and date: _____ Signature (parent or guardian):

Student's Health Insurance Company:
Policy Number:

Please provide the school with a copy of the medical insurance card which covers your child/children of all medical and accidents during their school term. **Day students**

SECTION I –STUDENT'S MEDICAL HISTORY

Has he/she, or does he/she suffer(ed) from:

- Any concerns about nutrition, eating habits, weight etc. ☐ YES ☐ NO
- Any trouble with sleeping habits ☐ YES ☐ NO
- Any allergies (food, insects, medication etc.) ☐ YES ☐ NO
- Any social, emotional or behavioural problem ☐ YES ☐ NO
- Any problem with vision, hearing or speech ☐ YES ☐ NO
- Any significant accidents or injuries ☐ YES ☐ NO
- Any lung problems/asthma ☐ YES ☐ NO
- Any concerns about kidneys or uro-genital system ☐ YES ☐ NO
- Any learning differences (e.g. dyslexia or other) ☐ YES ☐ NO
- Diabetes (if yes, state type) ☐ YES ☐ NO

_____

- Any orthopedic trouble ☐ YES ☐ NO
- Epilepsy ☐ YES ☐ NO
- Any heart trouble (heart murmur etc.) ☐ YES ☐ NO
- Any recurrent illnesses (tonsillitis, headaches etc.) ☐ YES ☐ NO
- Any skin problems ☐ YES ☐ NO
- Others ☐ YES ☐ NO

_____

Please explain any "Yes" answers from above. (Nature and frequency of the trouble, last episode, intensity etc.)

_____

_____

_____

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TEL +41 (0)33 744 13 72 FAX +41 (0)33 744 89 82 **info@jfk.ch** **www.jfk.ch**

SECTION II - **PAST ILLNESSES** Please check the correct response, and give date if possible:

		Date			Date
• Mumps	☐ YES ☐ NO	_____	• German measles	☐ YES ☐ NO	_____
• Scarlet Fever	☐ YES ☐ NO	_____	• Whooping cough	☐ YES ☐ NO	_____
• Chickenpox	☐ YES ☐ NO	_____	• Diphtheria	☐ YES ☐ NO	_____
• Measles	☐ YES ☐ NO	_____	• Pneumonia	☐ YES ☐ NO	_____
• Other	☐ YES ☐ NO	_____	(Mononucleosis, tuberculosis, typhoid, malaria, Pfeiffer etc…)		

SECTION III - **GENERAL ISSUES**

Has the student ever spent time in hospital or undergone surgery? If so, give details.

☐YES ☐NO _____

Does the student take medication regularly or occasionally? If so, which and for what reason?

☐YES ☐NO _____

Is there any reason that the student may not participate fully in school activities, including physical education? If yes, give the reason, and the necessary restriction/adaptation:

☐YES ☐NO _____

Does your child follow any psychological or psychiatric treatment? If so, please give details:

☐YES ☐NO _____

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 authorise the school to act on my behalf in arranging whatever treatment appears necessary.

☐YES ☐NO

SECTION IV - **VACCINATIONS** Please check the correct response and give date if possible:

		Date			Date		Date
• Hepatitis A+B Twinrix	☐ YES ☐ NO	_____	• Tetanus	☐ YES ☐ NO	_____	• Booster ☐ YES ☐ NO	_____
• Hepatitis A	☐ YES ☐ NO	_____	• Poliomyelitis	☐ YES ☐ NO	_____	Type of vaccine	_____
• Hepatitis B	☐ YES ☐ NO	_____	• Diphtheria Tetanus-Whooping cough (Di-Te-Per)			☐ YES ☐ NO	_____
• Tuberculosis BCG	☐ YES ☐ NO	_____	• Diphtheria Tetanus-Polio (Di-Te-Pol)			☐ YES ☐ NO	_____
• Tuberculine test	☐ YES ☐ NO	_____					
	☐ Successful ☐ Unsuccessful						
• Other vaccinations	☐ YES ☐ NO	_____	Type of vaccine(s)		_____		
• Serums (e.g. anti-tetanus)	☐ YES ☐ NO	_____	Type		_____		

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SECTION V – **PHYSICIAN'S ANALYSIS** (only for new students or change of circumstances)

On the basis of the 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:

_____

_____

_____

Date: _____ Signature and stamp of Physician: _____

Name, Address and phone number of Physician:

_____

_____

_____

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