



Admission No:.....

Form No :6/Feb 2021

Pre-Admission Medical Form for Students

Note: PLEASE USE **BLOCK** LETTERS TO COMPLETE THIS FORM. Please return this with the admission form.

SURNAME: FIRST NAME:.....

DATE OF BIRTH: GENDER: MALE / FEMALE

PARENT/ GUARDIAN:

NAME.....

ADDRESS:

.....
.....
.....

EMERGENCY TEL. NO.:.....

.....

EMAIL ADDRESS:

Please ensure that you inform the school of any changes in address/telephone nos./ email.

1. Child's blood group:.....

2. CHILD'S MEDICAL HISTORY

Has your child ever had consultation or treatment for any ailments?

SPECIALIST	WHEN	REASON	TREATMENT

CHILD'S PRESENT HEALTH:

3. Is your child receiving any medical attention at present?

Yes	No
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If yes, for what reason?.....

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.....

4. Does your child have allergies?

Please provide details and reactions of any allergies.....

.....

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5. a Has your child had an eyesight test?

Yes	No
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b.Does your child require glasses?

Yes	No
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6. Does your child have any of the following?

CONDITION	
EPILEPSY	YES / NO
DIABETES	YES / NO
HEART CONDITION	YES / NO
THYROID DISORDER	YES / NO
ASTHMA	YES / NO
RECURRENT HEADACHE/ MIGRAINE	YES / NO
BACKACHE	YES / NO

Please record here any other condition your child has / does suffer from, including treatment:

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7. Does your ward have developmental delays / learning disabilities? If yes, please give details and treatment taken.

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Would your child require special assistance at School? If yes please give details

Details:

.....

8. Has your child shown or been treated for any of the following problems in the last twelve months?

AGRESSION	YES	NO
DEPRESSION	YES	NO
TEMPER TANTRUMS	YES	NO
EATING DISORDERS	YES	NO

If yes to any of the above, please give details:

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Parent declaration:

I parent of Declare that the above given data is to best of my knowledge.

Place :

SIGNATURE OF THE PARENT / GUARDIAN

Date :

(NAME IN CAPITAL LETTERS)

