BHS Medical Department - Confidential Student Health Form

Student's first name: ______________________________ Last name: __________________________________

Gender: (F) ___ (M)____ Class: ___________

Date of birth: ____________________________________ Nationality(ies): _______________________________

Father's name: __________________________________ Phone number: _______________________________

Mother's name: __________________________________ Phone number: _______________________________

Address: ____

Person to inform in case of emergency: ____

Name of guardian: _____________________________________ Relation: _______________________________

Phone number: __________________________

1. Please give details of significant past sickness or operations from infancy until now: ________________________

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2. Does your child have any condition requiring regular treatment or check-ups with a doctor? Yes [ ] No [ ]

If yes, please state what your child suffers from and if child needs medication during school hours, please contact school doctor/nurse to make arrangement and fill medication permission form:

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3. Allergies (including drug allergies) - if any, please state: ____

4. Are there any other worries you have concerning your child? For instance, frequent colds, headaches, stomach pain, emotional, mental, speech problem etc.

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5. Are there any medical reasons for limitation or exemption from any physical activity while at school?

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6. Immunisation record: (please give dates or a photocopy of immunisation card)

DTaP+IPV+Hib____

Booster DTaP______________________________ Meningococcus ______________________________

Pneumococcus______________________________ ______________________________

Hep B ______________________________ COVID______________________________

MMR ______________________________ Typhoid______________________________

Rotavirus______________________________ Influenza______________________________

Varicella ______________________________ HPV______________________________

BCG ______________________________ Tuberculin test______________________________

Hep A______________________________ Reaction ______________________________

7. Does your child have any known or suspected hearing defect? Yes [ ] No [ ]

8. Does your child have any problems with vision? Yes [ ] No [ ]

9. The school will NOT administer any medication to student without written permission from their parents:

- The school nurse has my permission to give my child/ren over the counter medicines (e.g. analgesia, antipyretic, cough medicines, throat lozenges and apply creams or antiseptic agents for wounds) in case needed.
- I authorize the school nurse to proceed with the treatment, if my child/ren appear to require immediate medical treatment.
- I authorize the school doctor/nurse to release information to concerned staff or whenever it is medically needed for the care of my child/ren.
- In case a health concern is suspected, the school doctor/nurse has my permission to perform a physical examination (mouth, eye, ears, nose, lice detection, body and pain location) (auscultation, inspection, palpation and percussion).

10. I understand that, in an emergency, the school will take any medical action considered necessary.

The medical department urges you to complete this form and return it at the beginning of the school year.

PARENT'S SIGNATURE: ____ DATE: ________________________

FAMILY DOCTOR: _________________________________ SIGNATURE: _________________________________