



# Medical Form

Student's Name: \_\_\_\_\_

Nationality: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_

Admission date & school year: \_\_\_\_\_

**1. Please indicate if your child has - or has had - any of the following medical conditions. Please mark (X) the appropriate box. Give any details, including dates and any current medication.**

Details	Yes	No	Uncertain	
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div style="border: 1px solid black; height: 400px; width: 100%;"></div>
Allergic reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bone / joint injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic / recurrent illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dental / orthodontic treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ear infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glandular fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glasses / contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches / migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rubella (German measles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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2. Please indicate vaccinations that your child has received.

Vaccinations	Immunization Dates (please list)			
	1st	2nd	3rd	4th
Poliomyelitis TOPV - Tyi / Oral vaccine				
DPT (Tetanus, Polio, Diphtheria)				
TD (Tetanus, Diphtheria)				
Mumps				
Measles				
Rubella (German measles)				
MMR (combined Mumps, Measles, Rubella)				
Hepatitis A				
Hepatitis B				
Japanese Encephalitis				
BCG (Tuberculosis)				
Other (please give details)				

3. Has anyone ever talked to you about concerns in the area of child development, emotional and behavioral difficulties?

Yes

No

If yes, please give details.



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## 4. Does your child have any allergies?

Yes

No

If yes, please specify and describe what happens.

What is the necessary treatment?

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## 5. Does your child have any asthma?

Yes

No

If yes, has your child been hospitalized for the control of asthmatic symptoms?

Please indicate where and approximate date(s).

What medication does your child take? What dose? How often?



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**6. Does your child have any injuries?**

Yes

No

If yes, please give details including any surgical procedures and approximate dates.

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**7. Does your child have any restrictions on physical activity?**

Yes

No

If yes, please give details and attach a certificate from an accredited medical doctor.

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**8. Is your child on long-term medication?**

Yes

No

If yes, please give details.

If you would like the school nurse to administer or manage this medication, please complete the form on the next page.

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**9. If your child complains of a minor pain at school, e.g. headache, would you be willing for the school nurse to give a mild analgesic like paracetamol / tylenol?**

Yes

No

If yes, please complete the form below.

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## 10. Please provide your child's medical insurance details.

Insurance Provider	Policy Number	Emergency call centre number

(The emergency call centre number is the telephone number that the insurance company asks you to call in the events of an emergency.)

- Please note that BWYA students are expected to have their own medical insurance.
- It is the responsibility of the student's parents / legal guardian(s) to ensure that the students are covered with current and comprehensive health insurance during their time at the Academy.
- Please keep the school updated of any changes to health and contact details of your children.

Medications Consent Form		
I hereby authorize the BWYA nurse to administer a mild analgesic to manage minor pain if requested by my child and the following medication(s) as prescribed.		
Medication name(s)		
What the medications are for		
Dosage / Quantity		
Time / Frequency		
Signature	Name	Date
Important notes: <ul style="list-style-type: none"> <li>• Prescription medication is not allowed to be carried in student's personal belongings.</li> <li>• Medications can be stored and dispensed by the school nurse.</li> <li>• The label should include student's name, name of drug, frequency and dose to be given.</li> <li>• All prescription medication requires written parental consent.</li> </ul>		

### Please return to:

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