Attach Photographs Here

2019/2020

MEDICAL FORM

IT IS IMPERATIVE FOR THE STUDENT'S WELFARE THAT THIS SECTION OF THE APPLICATION FORM BE COMPLETED THOROUGHLY:

1. Name of Student: _____
2. Academic Year: _____
3. Age: _____
4. Home Telephone: _____
5. Mobile Number (s):_____
6. In case of an emergency and if the school is unable to contact the parents, please notify:
Name: _____ Relationship to student: _____
Home Telephone: _____
Mobile Number (s):_____
7. Do you agree that the school supervises your child's vaccinations periodically and as indicated by and under the supervision of the Ministry of Health:

☐ ***Yes***

☐ ***No. If so, please realize that you as a parent are therefore responsible for all your child's future vaccinations which the Ministry of Health will ask you to verify***

8. Does the student suffer from one or more of the following? If so, please give details:

	Yes	***No***	***Please give details***
****Chest Asthma***			
****Food Allergies***			
****Drug Allergies***			
****Diabetes***			
****Past history of surgery***			
****Convulsions due to high fever***			
****Other, Please give details :***			

9. Name of Pediatrician / Family Doctor: _____Telephone: _____
10 . A copy of the vaccination certificate of the child is required.

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