Medical Form

Student's name: _____ Gender:

Date of birth: _____ F ☐ M ☐

Doctor's name: _____ Grade: _____

Hospital: _____ Phone numbers: _____

Address: _____

Mother's Information

Mother's name: _____ Mobile phone number: _____

Home phone number: _____ Work phone number: _____

Father's Information

Father's name: _____ Mobile phone number: _____

Home phone number: _____ Work phone number: _____

Emergency Contacts (In case parents are not contacted)

Contact 1:

Name: _____ Mobile phone number: _____

Home phone number: _____ Work phone number: _____

Contact 2:

Name: _____ Mobile phone number: _____

Home phone number: _____ Work phone number: _____

Does the student suffer from a chronic disease?

Please specify. _____

Does the student have any physical or mental illnesses that could influence his/her academic progress? If so, please complete the following section.

Health Areas of Interest

Please mark the problem areas with an X.

Asthma ☐ Bronchitis ☐ Diabetes ☐ Hyperactivity ☐ Epilepsy ☐

Heart disease ☐ Throat infections ☐ Nose bleeds ☐ Ear infections ☐ Dizziness ☐

Digestive problems ☐ Skin conditions ☐ Vision problems ☐ Kidney problems ☐

Does the student take any medications regularly? Yes ☐ No ☐

If so, please complete the following section:

Medication name: _____ Dose: _____

Prescribed for (illness): _____ Additional information: _____

Does the student suffer from an allergic condition? Yes ☐ No ☐

If so, please complete the following section:

Allergic to:

Medications: _____

Foods: _____ Animals/insects: _____

Others: _____

Please mention any information you consider to be relevant to the nurse or the teacher:

_____

_____

_____

_____

_____