

Please attach
recent photograph

MEDICAL FORM (pg 1 of 5)

STUDENT'S PERSONAL INFORMATION

(Please write in block capitals. All information will be treated as Confidential)

a) Student Particular:

Name: _____ *Male / Female
Name according to Birth Certificate. Please underline Family Name

Date of Birth: _____ Nationality: _____

I/D Card No: _____ Religion: _____

Passport No: _____ Date of Expiry: _____

Date of Issue: _____ Place of Issue: _____

Email Address: _____

b) Student Lives With: (Please tick where applicable)

- | | | | |
|-----------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Father | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Father is deceased | <input type="checkbox"/> Parents are separated |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Mother is deceased | <input type="checkbox"/> Parents are divorced |
| <input type="checkbox"/> Guardian | <input type="checkbox"/> Others | | |

PARENTS' INFORMATION

(NB: When a student's natural parents are no longer living together, it is important to provide Guardian's contact details.)

Father's Name: _____

Mother's Name: _____

Guardian's Name: _____

Home Address: _____

Postal Code: _____

Home Tel: _____ Home Fax: _____

Handphone: _____ Email: _____

Office Tel: _____ Office Fax: _____

URGENT CONTACT NOS:	Name:	
	Relationship:	

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MEDICAL HISTORY *(please attach immunization records if available)*

 1) Has the student been properly immunized against (please tick box):

	<u>Yes</u>	<u>No</u>	<u>Date of last Booster dose</u>
a) Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	_____
b) Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
c) Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	_____
d) Smallpox	<input type="checkbox"/>	<input type="checkbox"/>	_____
e) Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____
f) Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	_____
g) Tuberculosis (BCG)	<input type="checkbox"/>	<input type="checkbox"/>	_____
h) Cholera	<input type="checkbox"/>	<input type="checkbox"/>	_____
i) Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____
j) German Measles (Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	_____
k) Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
l) Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____

2) Has the student had:

a) Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>
b) Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
c) Glandular Fever (Infective Mononucleosis)	<input type="checkbox"/>	<input type="checkbox"/>
d) Typhoid	<input type="checkbox"/>	<input type="checkbox"/>
e) Malaria	<input type="checkbox"/>	<input type="checkbox"/>
f) Pulmonary Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
g) Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>
h) Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
i) Others <i>(if yes, please elaborate)</i>	<input type="checkbox"/>	<input type="checkbox"/>

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- 3) Has the student any allergies to drugs, food or any other things? If yes, please give details. *Please provide details of EpiPen usage if applicable.*

- 4) Has the student any special medical problems that the School should know of, eg epilepsy, nephritis, diabetes, asthma, migraine, psychiatric disorder?
If yes, please give details.
Please provide information for Asthma management plan if applicable.

- 5) Has the student ever been admitted into a hospital or undergone any surgery?
If yes, please give details.

- 6) Is the student on medication: short-term, long-term? If yes, please give details

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7) Does the student require a special diet? If yes, please give details

8) Please give details of any physical aids worn by the student, eg glasses, hearing aid, braces:

9) Has the student any disability which will restrict him/her in participating in the physical education programme? If yes, please give details.

10) Applicable for **Girls only**: Have they started menstruation? Do they experience any difficulties that the school should be aware of and to provide assistance should the circumstances arise?

MEDICAL FORM (pg 5 of 5)**AUTHORIZATION & DECLARATION**

I hereby authorize:

- i) The School to give first aid treatment;
- ii) All other illnesses to be attended to by the School appointed Doctor if the school is unable to contact parents or guardian;
- iii) The Principal or School representative to act on my behalf and give the required consent for operations and anesthetics in the event of emergency surgical or dental treatment being necessary for my child. I recognize that it may not always be possible for the member of School staff authorizing such emergency treatment to inform me before this treatment is administered, though all reasonable efforts will be made to do so.
- iv) I give permission for school to administer panadol. Yes No

Declaration:

I certify that I have answered as fully as possible all questions about my *child's / ward's health. The information that I have provided is true and to the best of my knowledge.

I also hereby acknowledge that it is my responsibility to inform the School, in writing, should there be any changes in my *child's / ward's medical condition.

Signature of *Parent / Guardian

Date

Name of *Parent / Guardian (*please write in BLOCK*)

NB: Please indicate "NA" where not applicable



Emergency Contact

1	Name		Mobile No.	
	Telephone No.		Office No.	
2	Name		Mobile No.	
	Telephone No.		Office No.	

*In the case of emergency if you cannot be contacted, which is your **preferred** hospital?*