Health Records

Immunization Record:

1. Please check if she has been immunized against any of the following discuses. (Give dates if known)

☐ Whooping cough ☐ Measles ☐ Tetanus ☐ Diphtheria

☐ Polio ☐ B.C.G ☐ Cholera ☐ Rubella

☐ Typhoid ☐ Others .....

2. Please check if she had any of the following diseases: ☐ Yes ☐ No

☐ Chicken Pox ☐ Measles

☐ Mumps ☐ Rubella (German measles)

☐ Hepatitis (Jaundice) ☐ Others: .....

3. Details of any treatments or medications she is presently receiving:

.....

4. Is your child suffering from diabetes? ☐ Yes ☐ No

5. Does she have an allergic reaction to any medication or other substances? ☐ Yes ☐ No

6. Please list any serious illnesses, accidents, or operations she has had:

.....

7. Does she have any hearing difficulties? ☐ Yes ☐ No

8. Does she need eyeglasses? ☐ Yes ☐ No

Does she have any problems with her vision? ☐ Yes ☐ No

If yes, please explain: .....

9. Does she have any difficulties or disabilities which may affect her school performance? ☐ Yes ☐ No

If yes, please explain: .....

Person(S) to be contacted in case of emergency:

Name: ..... Relationship: ..... Phone: .....

Name: ..... Relationship: ..... Phone: .....

I approve that in the event parents of other people named on the health form cannot be contacted, the school officials are authorized to take necessary actions required for the health of the student.

Parent's Signature: ..... Date: .....