مدرسة كارديف الدولية
CARDIFF INTERNATIONAL SCHOOL

MEDICAL FORM

Child's name:_____ Year_____

Please complete all sections of this medical form and return to the school.

A. INFECTIOUS DESEASES (Use "√" to fill)			
Has your child ever had:	**YES**	**NO**	If yes, date of infection
Chickenpox			
Diphtheria			
German Measles			
Measles			
Mumps			
Polio			
Scarlet Fever			
Tuberculosis			
Whooping Cough			
B. OTHER CONDITIONS			
Does your child suffer from:	**YES**	**NO**	If yes, what treatment does the child require?
Asthma			
Epilepsy			
Diabetes			
Anaphylaxis			

Other (Please give details)

_____

_____

SERIOUS ILLNESS / MAJOR SURGERY		
Please give details and any medication being taken by your child. _____ _____ _____		
HEALTH HISTORY		
Does your child suffer from any allergies? E.g. food, drugs, environment	**Yes ◯**	**No ◯**
Please give details: _____ _____ _____		
Does your child needs any regular medication?	**Yes ◯**	**No ◯**
Please give details: _____ _____ _____		
PERMISSION FORM		
Do we have permission to provide emergency care through a clinic, hospital, private doctor or school first aid person as necessary?	**Yes ◯**	**No ◯**
Do we have your permission to provide CALPOL in case of mild fever?	**Yes ◯**	**No ◯**

Parent's / Guardian's Name	**Signature**	**Date (Dd/mm/yyyy)**