BANGKOK PREP
Bangkok International Preparatory & Secondary School
Est. 2003

Medical History Form
(Please complete this form in CAPITAL LETTERS)

Student Name: _____
Date of Birth: _____ **Year Group:** _____

If your child has any pre-existing medical conditions e.g. asthma, diabetes, allergies, nose bleeds, etc. please provide details:	
Condition:	Details (including severity and treatment required)

If your child has any special dietary requirements please provide details: eg. allergies

Please give details of the following for your child:

Does your child have a:	Yes	No	Details
Visual impairment	☐	☐	
Hearing impairment	☐	☐	
Coordination/ Development disorder	☐	☐	
Skin condition	☐	☐	
Speech impediment	☐	☐	
Or any previous medical operations or other relevant information we should be aware of	☐	☐	

Does your child take any regular medication? Yes☐ No ☐

If yes please provide details:			
Medication	Prescription/Dose	Required to be given at school	
		Yes*	No
		☐	☐

*Please ensure that you arrange to meet with the Nurse if medication is required to be administered during the school day

Vaccinations / Immunisations:

Vaccination	Yes	No	Date
Diphtheria (1st year)	☐	☐	
Diphtheria (3-5 years)	☐	☐	
Whooping cough	☐	☐	
Tetanus (1st year)	☐	☐	
Tetanus (3-5 years)	☐	☐	
Measles	☐	☐	
Mumps	☐	☐	
Rubella	☐	☐	
Polio	☐	☐	
Tuberculosis	☐	☐	
H.I.B. vaccine	☐	☐	
Meningitis A and C	☐	☐	
Hepatitis A	☐	☐	
Hepatitis B	☐	☐	

This form is confidential. If your child has a medical condition which you would prefer to discuss only with the School Nurse, she is available for appointments during school hours. Please contact the School Nurse directly via email primarynurse@bkkprep.ac.th or secondarynurse@bkkprep.ac.th

I hereby confirm that there are no other medical problems that affect my son/daughter, which are known to me at this time.

I understand, that in the event of an emergency that all efforts will be made to contact my child's emergency contacts, but that if this is not possible, that my child will be taken to a suitable hospital for treatment.

Mother's/Father's/Guardian's Name: _____

Mother's/Father's/Guardian's Signature: _____ Dated:_____

Emergency Contact #1
Name: _____ Relationship: _____
Contact number #1_____ #2_____

Emergency Contact #2
Name: _____ Relationship: _____
Contact number #1_____ #2_____

For office use only:	
Date received: _____ Date entered on to iSAMS:_____ Staff name: _____	Red Flag: Yes / No Nurse notified: Yes /No Class teacher notified: Yes / No Canteen notified: Yes / No