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

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: ____________________	Red Flag: Yes / No
Date entered on to iSAMS:___________	Nurse notified: Yes /No
Staff name: ______________________	Class teacher notified: Yes / No
	Canteen notified: Yes / No