MEDICAL FORM

First Name: _____ Last Name: _____ Year: _____

1. Please provide a copy of innoculations/vaccination records.

2. Does your child have any of the following? (Please check ☑ where relevant)

❒ Asthma	❒ Hayfever	❒ Sight problems
❒ Chicken Pox	❒ Headaches	❒ Stomach problems
❒ Diabetes	❒ Hearing problems	❒ Tuberculosis
❒ Ear Infections	❒ Heart problems	❒ Other_____
❒ Eczema	❒ Infectious diseases	
❒ Epilepsy	❒ Neurological disease	

3. If you checked any boxes above, please describe:
_____

4. Does your child have any **ALLERGIES**? ❒Yes ❒No If yes:
Allergic to: _____Typical Reaction: _____

5. Medication (if any) taken:
_____

6. Has your child had a serious operation? ❒Yes ❒No *If yes, please provide details:*
_____

7. Does your child take any medication (oral or injected) on a regular basis? ❒Yes ❒No
If yes, please provide details: _____

8. Does your child wear glasses or contact lenses? ❒Yes ❒No

9. Has your child had received the following vaccinations?

**Note some vaccines are combined or given together. Please complete the dates for both childhood and booster vaccinations in the appropriate box.*

	Date (dd/mm/yy)				
Type	1st	2nd	3rd	4th	5th
Measles/Mumps/Rubella (MMR*)					
Diptheria/Pertusis/Tetanus (DPT/DTaP/Td*)					
Poliomyelitis (TOPV/IPV*)					
Hepatitis B (3 injections)					
Tuberculosis (B.C.G.)					
Haemophilus influenzae type B (Hib)					
Chicken Pox					

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www.suzhou.dulwich.org

MEDICAL FORM

MEDICAL DETAILS IN CASE OF EMERGENCY:

In case of an accident/illness and I cannot be reached please contact (OTHER THAN PARENTS):

Emergency Contact: _____ Relationship: _____

Tel (H): _____ Tel (O): _____

Mobile: _____ Email: _____

MEDICAL INSURANCE DETAILS:

Name of Primary Insurer (parent): _____

Name of Insurance Company: _____

Name of Plan: _____

Group Insurance Number: _____

Individual Insurance Number: _____

24-hour Emergency Number: _____

Please note that your child will be taken to the medical facility nearest to his/her school campus if emergency treatment is required.

Parent Name:

Parent Signature:

Date:

Please send this completed form along with a copy of your child's vaccination records to dcsz.nurse@dulwich.org.