



1st INTERNATIONAL SCHOOL OF OSTRAVA[®]

Health Insurance Company

Number

INTERNATIONAL PRIMARY SCHOOL

STUDENT MEDICAL FORM (Please complete in BLOCK CAPITALS)

Please complete all details below and return this form to the School Management Team..

PARTICULARS OF THE CHILD

Surname: _____

First, middle name: _____

Date of birth: (DD/MM/YY) _____

Place of Birth: _____

Nationality: _____

Gender: Male Female

Parents/Guardians: Name 1 _____ Name 2 _____

EMERGENCY CONTACT

Name: _____

Telephone: _____

PLEASE INDICATE IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING ILLNESSES:

	NO	YES	DATE
Chicken Pox			
Whooping Cough			
Rubella			
Tuberculosis			
Mumps			
Pneumonia			
Tonsillitis			
Frequent Colds			
Frequent Ear Infection			

PLEASE INDICATE IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING CONDITIONS:

	NO	YES
Asthma		
Allergies		
Diabetes		
Epilepsy		
Fainting		
Heart Trouble		
Hearing Difficulty		
Impaired vision		
Speech Difficulty		
Concentration Difficulty		
Behaviour Problems		
Other		



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OTHER INFORMATION

Is your child currently under medical supervision or routinely receiving medication? YES NO

If yes, please describe below.

Is there any reason for your child to have restricted physical activity? YES NO

If yes, please describe below.

Other medical/health information you may wish to include that may help us understand your child's health needs:

IMMUNIZATION

Please attach a photocopy of your child's immunization record in English.

MEDICAL PERMISSION

I authorize the school to administer non-prescription medicine to my child as appropriate.

YES NO

If you would like to be informed first, tick here. YES

ACCIDENT TREATMENT PERMISSION

I understand all efforts will be made to contact parents first, emergency contact second and if neither are available I hereby give permission for emergency measures to be initiated in case of accident or sudden illness.

I certify that all information given is correct and complete.

Signature of Parent / Guardian: _____

Date: _____