المدرسة الآسيوية الدولية الخاصة
ASIAN INTERNATIONAL PRIVATE SCHOOL

STUDENT MEDICAL RECORD

Student Photo

Admission No: _____

Name of Student:	
Home Address:	
Date of Birth:	
Gender:	
Blood Group:	
School clinic medical record number:	
Nationality:	
Next of kin (Parents or Legal Guardian) :	
Contact person with address and contact numbers:	
Religion:	
Medical History:	
Allergies:	
Problem List:	
Immunization Status:	

Dear Parent,

Pleas fill out the form and attached **1PC. PASSPORT SIZE PHOTO** and **VACCINATION RECORD COPY** and submit to school.

PERSONAL DATA

	Gender		Nationality		Place of Birth		Date of Birth

	Business Tel. No.		Educational Level		Profession		Father's Name
	Business Tel. No.		Educational Level		Profession		Mother's Name

Residence Tel. No.	City	Street	Area	P. O. Box	Email

In case of Emergency please contact:

Telephone:	Mr./Miss/Mrs. :
Mobile No.:	Relationship:

Please mark (YES) or (NO) if your child has health problems.
If YES, please give dates and explanation in space below.

NO	YES	PROBLEMS	NO	YES	PROBLEMS
		Gum & Teeth Diseases			Physical or Mental Handicap
		Recurrent Ear Infections			Learning Difficulty
		Loss of Consciousness			Speech Problem
		Epilepsy			Visual Problem
		Bleeding Tendencies			Hearing Problem
		Bronchial Asthma			Snoring During Sleep
		Tuberculosis			Deformities of Vertebral Column
		Heart Disease			Obesity
		Kidney Disease			Hospitalizations
		Diabetes			Surgical Operations
		Health Aid Requirement (Hearing, orthopedic, etc..)			Medical Restriction on Physical Activity
					Others

Explanation (Please include details about problems for which you checked YES above or any problems you wish to inform the school on a separate paper).

STUDENT'S NAME: _____

CURRENT MEDICAL CONDITIONS

Chronic Health Problem
Regular Medication
Medication for Emergency
Precautions for Sports or Food
Allergy from
1 – Medicine
2 – Food
3 – Others

STUDENT'S NAME: _____

SOCIAL HISTORY

Please mark YES or NO regarding the student and family. If YES, please give dates and explanations.

NOTES	NO	YES	PROBLEMS / QUESTIONS	
			Divorce	
			Polygamy	
			Family Dispute	
			Financial problems	
			Consanguinity	
			Any problem during perinatal period	
			Nocturnal Enuresis	
			Appetite Problem	
			Sleeping Problem	
			Psychological/Hereditary Diseases	
			Learning Difficulties	

FAMILY HISTORY

								Age		Number of Sisters
								Age		Number of Brothers
The order of student among brothers or sisters.										

Please mark (with an X) problems your child's family members have or may have had in the past.

	Other Problems	Smoking	Heart Diseases	High Blood Pressure	Diabetes
Father					
Mother					
Siblings					

IMMUNIZATION STATUS

PRE SCHOOL VACCINATION

Type of vaccination	1st Dose	2nd Dose	3rd Dose	Booster	Place of vaccination	Remarks
	Date	Date	Date	Date		
BCG						
DPT						
Hib						
Hepatitis B						
OPV - IPV						
MMR						

SCHOOL AGE VACCINATION

Name of Vaccine		Date of Vaccination	Site of Vaccination	Company	Date of Manufacture	Expiry Date	Lot Number	Signature
MMR								
DT								
Polio / OPV								
RUBELLA								
Td / OPV								
HPV	1st Dose							
	2nd Dose							
	3rd Dose							