



LEADERS INTERNATIONAL CHRISTIAN SCHOOL

STUDENT MEDICAL INFORMATION

Student Name: _____
Last Name Given Name Middle Name

Date of Birth: ___/___/___ Current Age: _____ Sex: _____

Address: _____

Persons to Contact in Case of Emergency:

1. Name: _____ Relationship to Child: _____

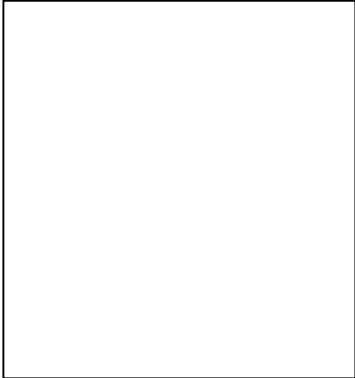
Telephone Number: _____ Mobile Number: _____

2. Name: _____ Relationship to Child: _____

Telephone Number: _____ Mobile Number: _____

Pediatrician's / Family Physician's Name: _____ Contact Number: _____

Hospital's / Clinic's Address: _____



Please complete the following sections:

I. MY CHILD HAS

Please Check the Appropriate Boxes

	No	Yes		No	Yes
Asthma			Migraine Headaches		
Diabetes (Sugar)			Kidney Problems		
Convulsions			Monthly Menstruation		
Cerebral Palsy			Others: Please Specify		

If yes for any of the above, please specify medications, frequency and process in administering medication:

II. MY CHILD IS ALLERGIC TO

Food	Drug	Insects	Others: Please Specify

If yes for any of the above, please specify medications, frequency and process in administering medication:

III. IS YOUR CHILD TAKING ANY MEDICINES ON A REGULAR OR PART TIME BASIS?

No Yes If yes, please Indicate: _____

IV. MY CHILD USES THESE AIDS

Please Check the Appropriate Boxes					
	No	Yes		No	Yes
Contact Lenses			Hearing Aid		
Eyeglasses			Crutches		
Braces for Arm or Leg			Dental Plate		
Wheelchair			Others: Pls Specify		

V. DO YOU NEED THE SCHOOL'S HELP WITH REGARDS TO YOUR CHILD'S HEALTH?

No Yes If yes, please Explain: _____

VI. IMMUNIZATION HISTORY

	Please provide us with dates of immunization					
	1st	Reaction	2nd	Reaction	3rd	Reaction
BCG						
DPT						
Boosters						
Polio						
Boosters						
Hemophilus Influenza Type B						
Meningococcal						
Pneumococcal						
Measles						
MMR						
Typhoid						
Influenza						
Hepatitis A						
Hepatitis B						
Booster						
Chicken Pox						
Others, please specify:						

VII. PARENT / GUARDIAN SIGNATURE

Signature Over Printed Name

Date