MEDICAL REPORT

- This form is to be completed by the student's Doctor

- Once complete this form should be returned to the student's Agent

Student's Name

Date of Birth

Height

Weight

Blood type

Is there any reason why this student should not participate in normal school life, including physical education and sport?

◯ Yes ◯ No

If Yes, please provide details

Has he/she had any of the following infectious diseases?

☐ Chicken Pox ☐ Mumps ☐ Typhoid Fever ☐ Measles

☐ Hepatits ☐ Tuberculosis ☐ Whooping Cough ☐ Diphtheria

☐ Smallpox ☐ Polio ☐ German Measles (Rubella) ☐ Covid-19

If yes to any disease, please provide full details and dates.

Has he/she had any recurring problems with any of the following?

☐ Allergies ☐ Coughs ☐ Asthma ☐ Adenoids ☐ Tonsils

☐ Epilepsy ☐ Bronchitis ☐ Fits/convulsions ☐ Headaches ☐ Catarrh

☐ Glands ☐ Diabetes

If yes, please provide details

Does he/she have any problems with any of the following?

☐ Ears ☐ Nose ☐ Throat ☐ Teeth ☐ Speech ☐ Eyes ☐ Feet ☐ Skin

If yes to any of these, please provide details

Please continue on the next page.

Immunisations and Treatments

Has he/she been immunised against any of the following? Please indicate date administered (day/month/year). If the immunisations have not been administered within the past ten years the student may need to be immunised upon arrival.

Poliomyelitis	1st	2nd	3rd	4th	5th
Diptheria	1st	2nd	3rd	4th	5th
Tuberculosis (BCG)	1st	2nd	3rd	4th	5th
Tetanus (Active)	1st	2nd	3rd	4th	5th
Chicken Pox	1st	2nd	3rd	4th	5th
Whooping Cough	1st	2nd	3rd	4th	5th
MMR (2 required in US)	1st	2nd	3rd	4th	5th
Hepatitis B	1st	2nd	3rd	4th	5th
Covid-19	1st	2nd			

Any other immunisations

Please provide details of any major illnesses or operations

Has he/she been advised to have surgery which has not been carried out?

◯ Yes ◯ No

If yes, please provide details

Is he/she currently taking any medication or injections?

◯ Yes ◯ No

If yes, please provide details

Has he/she ever consulted a neurologist, psychologist, or other specialist in nervous or emotional disorder?

◯ Yes ◯ No

If yes, please provide details

Please continue on the next page.

I have reviewed the medical history of the above student and state that after this review and a medical examination all relevant medical information has been recorded on this form.

Name of Doctor

Date

Address

Signature

Instructions to Doctor

Please complete this form digitally and return it to the student's parents via email.

AND

Please print a copy of this form, sign it and return it to the student's parents.