



COLEGIO GRAN BRETAÑA

MEDICAL FORM

ACADEMIC YEAR: _____ GRADE LEVEL: _____

NAME OF PUPIL: _____

1. Is the student in good health? _____
Are there any health or physical limitations? _____

2. Does applicant wear glasses? _____ Should they be worn all times? _____
Is any special attention required, such as classroom seating or participation in sports? _____

3. Is there any hearing difficulty? _____ Is there any speech difficulty? _____
Has the student received any help or therapy in this area? _____
Explain _____

4. Has child ever had difficulties in: fine motor skills Gross Motor Skills
Has the student received any help or therapy in this area? _____
Explain: _____

5. Has child ever received emotional support? _____
Explain: _____

6. Has school attendance been steady and regular? _____ If there have been frequent absences, please indicate reason: _____

7. Has the applicant ever had surgery? _____ Why and when? _____

8. Allergies:	No	Yes	If yes, please give specific details
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pollen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insect	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

9. Has child ever been hospitalized? YES NO
If yes, please give date and reason for hospitalization: _____

10. Is child currently taking medication? YES NO
If yes, please list the medication(s): _____

Does child have a chronic (long-lasting or persistent) medical condition that requires treatment or medication?
YES NO

If yes, please have your physician send a summary of your treatment to include the following: Condition being treated, Type of medication, Physician's address & phone number.

11. PERSON(S) TO CONTACT IN THE EVENT OF AN EMERGENCY

Name: _____ Relationship: _____
Ph. # 1 _____ Ph.#2: _____ Ph. # 3: _____

Name: _____ Relationship: _____
Ph. # 1 _____ Ph.#2: _____ Ph. # 3: _____

12. MEDICAL INSURANCE INFORMATION:

Insurance Company Name: _____

Policy # _____ Group # _____

Hospital or Health Centre in case of emergency: _____

Please annex a photocopy of child's medical card.

13. BLOOD TYPE/TIPO DE SANGRE _____ FACTOR RH _____

VACCINATIONS VACUNAS	DATE FECHA	BOOSTER N° 1 REFUERZO N° 1	BOOSTER N° 2 REFUERZO N° 2	BOOSTER N° 3 REFUERZO N° 3
MMR Trividal				
Polio				
Chicken Pox Sarampión				
Rubella Rubeola				
Tuberculosis				
Hepatitis B				
Meningitis				
German Measles				

14. Do you authorise the school to give Dolex (paracetamol) to your child when necessary?

Yes No

15. TO BE COMPLETED ONLY BY DOCTOR FOLLOWING MEDICAL EXAMINATION

The subscribed doctor certifies that _____, enjoys good health, does not suffer from any contagious diseases which could prevent him/her from living within a community, and has his (her) immunisations up to date.

DOCTOR'S NAME: _____

PHONE: _____

DOCTOR'S SIGNATURE: _____

Registration N° : _____ Date: _____

Certificates for visual and hearing tests by a specialist must be annexed to this form.