

**NEFERTARI INTERNATIONAL SCHOOL**

**HEALTH FORM**

The School’s responsibility is to take optimum care of all our students. One of our aspects is to provide all students with the best medical attention available, including hygienic awareness. We would like to be familiar with any medical conditions concerning our children. We would be appreciative if you please send in a copy of their vaccinations, and fill in this form.

Student Name: ---------------------------------------------------------- Stage: ---------------

Date of Birth: --------/-------/---------- ABO System: ------------- Age Now: -----------

**MEDICAL HISTORY**

* Is allergic to anything (Medications, Food, or Drinks) Yes/No

 If yes, please Specify: ------------------------------------------------------------------------

* Has caught any contagious diseases (Measles, Mumps, or German Measles Yes/No

 If yes, please specify: --------------------------------------------------------------------

* Has any blood related conditions (Bleeding Tendency) Yes/No

 If yes, please specify: -------------------------------------------------------------------------

* Is on any regular medication (Bronchial Asthma or Diabetes) Yes/No

 If yes, please specify: ------------------------------------------------------------------------

* Is on any regular hospital visits: Yes/No

If yes, please specify: ------------------------------------------------------------------------

* Has undergone any surgical procedures: Yes/No

If yes, please specify: ------------------------------------------------------------------------

* Has any genetic inherited conditions: Yes/No

If yes, please specify: ------------------------------------------------------------------------

* Has any psychological problems: Yes/No

If yes, please specify: ------------------------------------------------------------------------

Comments: -----------------------------------------------------------------------------------------------

**I ------------------------------ parent of ----------------------- authorize NIS Physician to administer any appropriate treatment needed in case the school could not reach me or the emergency contacts.**

Parent’s signature: ------------------------

Date: -------/------/-----------