

Last Name _____ Firs/Givent Name _____ Middle Name _____ Sex _____ Date of Birth: ____/____/____
 _____ Day _____ Month _____ Year

 Address (Quartier) _____ Nationality _____

 Father's Name _____ Mother's Name _____

MEDICAL HISTORY

PERSONAL				FAMILY		
DISEASE/ILLNESS	DATE	DISEASE/ILLNESS	DATE	DISEASE/ILLNESS	YES	NO
Appendicitis		Measles, Red		Allergies		
Asthma		Meningitis		Asthma		
Chicken Pox		Parasites, Amoebic		Cancer		
Diabetes		Parasites, Other		Diabetes		
Epilepsy		Polio		Epilepsy		
Heart Trouble		Rheumatic Fever		Heart Trouble		
Hepatitis		Scarlet Fever		Tuberculosis		
Malaria		Typhoid Fever		Other		
Measles, German		Other				

ADDITIONAL HISTORY

ALLERGIES (Drug, Food, Environmental) _____

MEDICATIONS _____

DIETARY RESTRICTIONS _____

PHYSICAL DISABILITIES _____

BLOOD TYPE: (Circle One) **O A AB B** **RH FACTOR:** (Circle One) **Negative Positive**

OTHER CONDITIONS/OPERATIONS:	PMS
Heart Murmur/Irregularities	Emotional Difficulties/Depression
Eczema	Other: _____

If your child requires periodic/regular medical treatment, please give details:

IMMUNIZATIONS

DISEASE	DATE GIVEN	DISEASE	DATE GIVEN
*DPT (Diphtheria, Pertussis, Tetanus)		*Typhoid Fever	
*Polio Sabin (Oral)		Mantoux Tuberculin Test (Result)	
*Measles		BCG Tuberculin Vaccine	
*Mumps		*Meningitis	
Tetanus		Hepatitis A	
Cholera		Hepatitis B	
*Yellow Fever		Other	

* Required immunizations

Does the student wear glasses? Yes No Contact Lenses? Yes No Date of last eye exam: _____
 Does the student have a hearing problem? Yes No
 Does the student suffer from headaches? Yes No If so, occasionally or frequently? _____

PARTICIPATION IN PHYSICAL EDUCATION PROGRAM AND ON SPORTS TEAMS

My son/daughter, _____, has permission to participate in the physical education program at Rain Forest International School. He/she has no physical disability or health concerns that would prohibit his/her participation.

 Signature of Parent or Guardian