



## HEALTH QUESTIONNAIRE

### PERSONAL INFORMATION

NAME \_\_\_\_\_ M  F  DATE OF BIRTH \_\_\_\_\_  
NATIONALITY \_\_\_\_\_  
ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

### MEDICAL INFORMATION

Does the student suffer from any of the following?

Asthma	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Skin problems	<input type="checkbox"/>	Psychological problems	<input type="checkbox"/>
Other	<input type="checkbox"/>		

Comments \_\_\_\_\_

Has the student had any surgery? Yes / No

If yes, please give details including dates.

Does the student have any known allergies to food, medicine or other (eg: bee stings)? Yes / No

If yes, please give details.

Does the student have any regular medication? Yes / No

If yes, please give details including the prescribing doctor's name and dosage.

### VACCINATIONS (Please attach a copy of the vaccination certificate)

	Date		Date
Diphtheria	<input type="checkbox"/> _____	Mumps	<input type="checkbox"/> _____
Tetanus	<input type="checkbox"/> _____	German measles	<input type="checkbox"/> _____
Poliomyelitis	<input type="checkbox"/> _____	Whooping cough	<input type="checkbox"/> _____
Tuberculosis	<input type="checkbox"/> _____	Typhoid	<input type="checkbox"/> _____
Measles	<input type="checkbox"/> _____	Hepatitis A	<input type="checkbox"/> _____
		Hepatitis B	<input type="checkbox"/> _____

I declare the above information to be correct.

Date \_\_\_\_\_ Signature of physician \_\_\_\_\_ Parent signature \_\_\_\_\_

Physician's seal