If so, diagnosis and dosage :

Has the student's attendance at the school been so far, ever interrupted by an emotional or mental disturbance ? Please explain

Has the student had treatment on an outpatient basis by a psychiatrist or been hospitalized for an emotional disturbance ? Please explain

At present, do you believe the student needs to consult a psychiatrist, psychologist or medical staff while at school ?

Is there any illness or injury in the student's medical history, or any physical abnormalities, that would make it inadvisable or questionable for him to participate in physical education program, or to engage in contact sports ? If yes, please explain

PART IV : IMMUNIZATION RECORD

1. Diphtheria, pertussis, tetanus DPT (year original series competed)
2. Diphtheria, pertussis, tetanus DPT (year Booster given)
3. Polio (year original series completed)
4. Polio (Booster)
5. MMR (year of original & Booster)
6. BCG (year)
7. Chickenpox vaccine is recommended if the student has not suffered from chicken pox
8. Hepatitis-B (recommended) Dates : 1 2 3
9. Hepatitis-A (recommended) Date :
10. Typhoid (recommended) Date :

Doctor's Name : Signature :

Address :

Phone :

Parent's Name : Signature :

The Shishukunj
INTERNATIONAL SCHOOL
NORTH CAMPUS

Affiliated to Shishukunj International Foundation.

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FAMILIARIZATION FORM

Photograph of the Student

1. Name of the Student :
2. Date of Birth :
3. Father's Name :
4. Mother's Name :
5. Likes and Dislikes :
6. What does your child enjoy doing the most ?
7. Eating habits :
8. Allergies (if any) :
9. Blood Group :
10. Residence :

Tel. Father's (O) : Mobile :

Tel. Mother's (O) : Mobile :

Student's Health & Fitness form

A. MESSAGE TO THE STUDENT / PARENTS CONCERNING THIS HEALTH FORM

The school requires completion of this medical history and examination form.

The Student's health history, which is confidential, will in no way affect his school standing. The purpose of asking these questions is only to help the student and take all possible care.

The immunization record must be completed.

PART I : PERSONAL MEDICAL HISTORY *(To be filled in by the student/parents)*

Name : _____ Phone : _____
First Surname

Birth Date : _____ Sex : _____

Home Address : _____

_____
City State Pin

Parents / Guardians / trusted friend to be notified in an emergency : _____

Relationship : _____ Phone : _____

Address : _____

Has your ward ever had or do you have any of the following ?

(Check each item& tick yes/no) If yes, give details on the next page

	Yes	No
1. Allergy to medication		
2. Allergy to food or bee stings		
3. Respiratory allergy		
4. Anaemia or other blood disorder, sickle cell anemia		
5. Arthritis, Rheumatism, Rheumatic fever		
6. Asthma		
7. Attention Deficiency Disorder, Dyslexia, Insomnia, Sleep Walking		
8. Any Infectious Disease (Chickenpox, Measles, Mumps)		
9. Chronic Diarrhoea/Constipation		
10. Renal Disease, Night Wetting		
11. Epilepsy, Any episode of convulsion or unconsciousness		
12. Diabetes		
13. Any Skin Disease		
14. Any Surgical Operation		
15. Any injury or fracture		
16. Eye trouble or visual disorder		
17. Any Physical activity restriction?		
18. Any special diet?		

19. Any prescribed medication required on a regular basis ?
If so, list type and dosage

_____

_____

20. Any other disease in the past
If yes to any of the above, give details below or on a separate sheet. Please number the answers.

_____

_____

_____

MENSTRUAL HISTORY *(for girl students)* _____

Onset of Period (age) _____ Frequency _____ Duration _____

Irregularity _____ Painful periods _____

PART II : PHYSICAL EXAMINATION

(To be filled in by the doctor. Forms completed by parents will not be accepted.)

To The Doctor

(This form has been so designed that you can record your findings as simply and as completely as possible. We hope that together we can contribute to the student's present and future health. Thank you for your cooperation.)

Name : _____
Last First Middle

Date of Examination _____
Month / Day / Year

Height _____ cm Weight _____ kg Build : ☐ slender ☐ medium ☐ heavy ☐ obese

Blood Pressure _____ Pulse rate _____ Vision OD _____ with glasses if worn _____

Teeth _____ Dental treatment recommended _____ Blood Group _____

CLINICAL EVALUATION _____

Please check each item : enter NE if not evaluated

	Normal	Details of abnormality, if any
1. Head, Face, Scalp		
2. Nose, Throat, Mouth		
3. Ear		
4. Eyes-general		
5. Chest and Lungs		
6. Heart		
7. Abdomen and Viscera		
8. Musculoskeletal spines		
9. Hernia		
10. Neurological		

PART III : RECOMMENDATIONS *(To be filled by Doctor)*

Is treatment for a chronic ailment required (allergies, ADHD, emotional illness, any other) ? : _____

_____

Is any medication required ? _____

NORTH CAMPUS