HEBRON SCHOOL

OOTACAMUND, INDIA

PRE ADMISSION MEDICAL FORM FOR STUDENTS

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Note: PLEASE USE **BLOCK** LETTERS TO COMPLETE THIS FORM AND RETURN WITH ADMISSION FORM. All questions MUST be answered honestly. We reserve the right to refuse admission if this form is not completed. Moreover, **if a known medical condition is not disclosed, we reserve the right to ask for the student to be withdrawn even after admission**.

SURNAME: ……..

FIRST NAMES: ……..

DATE OF BIRTH: …….. **SEX: MALE / FEMALE**

SECTION A – PERSONAL HEALTH HISTORY: Tick the 'Yes' column and provide the date if known or write 'present' to indicate if the student has any of the following currently:

	Yes		Yes		Yes
Childhood diseases		Hay Fever		Ingrowing toenail	
Chicken pox		**Chest/Respiratory**		**Neurological conditions**	
Diphtheria		Asthma		Epilepsy	
Measles		Chronic cough		Febrile Convulsion	
Mumps		Chest pain		Fainting	
Polio		**Heart/Blood Disorder**		Frequent headaches	
Scarlet Fever		Heart Disease		Migraine	
Whooping cough		Other heart problem		Neuritis	
Other Conditions		High Blood Pressure		**Psychological conditions**	
Dengue		Low Blood Pressure		Aggression	
Diabetes		Haemophilia		Alcoholism	
Hepatitis (Jaundice)		Excessive bleeding		Anxiety	
Malaria		**GI/GU Conditions**		Depression	
Glandular Fever		Appendicitis		Drug habit	
Rheumatic Fever		Bladder infection		Eating disorder	
Tuberculosis		Diarrhoea/Dysentery		Emotional health issues	
Typhoid		Gall bladder		Hysteria	
Ear/Nose/Throat		Gastric irritation		Insomnia	
Frequent colds		Haemorrhoids		Nightmares	
Frequent earaches		Hernia		Psychiatric treatment	
Ear discharge		Kidney infection		Sleepwalking	
Frequent nose bleeds		**Skin Conditions**		Smoking habit	
Frequent sore throat		Eczema		Temper tantrums	
Tonsillitis		Impetigo		**Other (please specify)**	
Any deafness		Frequent boils			
Tooth/Gum problems		Scabies			

NB: Please note all children with a long-term health condition will require a current care plan, written by a physician).

Does your child have a physical disability, a special learning need such as dyslexia or sensory requirements? What assistance would your child require at School?

Please provide details:

……..

……..

Does the student wear glasses or contact lenses? Yes No

Has the student had any other eye condition such as a squint or required eye surgery?

Yes No

Please provide details:

……

Does the student have any hearing difficulties? Yes No

Please give details:

……

Does the student have a problem with bedwetting? Yes No

Is the student undergoing any ongoing dental treatment? Yes No

If so, will work be undertaken in the holidays or would you prefer school to arrange treatment locally? Please tick to confirm:

Treatment will be completed during the holidays OR

Treatment to be completed by dentist/orthodontist recommended by school

Females only:

Has your daughter commenced her periods? Yes No

Does the student have any problems with menstruation? Yes No

Does the student have any gynaecological problems? Yes No

If yes, please provide details:

……..

SECTION B – KNOWN MEDICAL CONDITIONS

Does your child have any allergies?
Please provide details and reactions of any allergies plus any necessary treatment:

……

Does your child suffer from any medical conditions for which they take medication to control symptoms? Eg: asthma, skin conditions, anxiety, insomnia etc.

If yes, please give details below including date diagnosed:

CONDITION	MEDICATION	DOSAGE	WHEN TAKEN	LAST REVIEWED

Has your child ever had a medical condition that involved seeing a specialist such as a Physiotherapist, Speech Therapist etc? Please provide details below:

……

……

Has your child had any of the following? Please give details:

Major Accidents:

……..

……

Operations, including fractures, listing dates and any reaction to general anaesthetic:

……..

……

Has your child ever been seen by an Educational-Psychologist or Psychiatrist? Please circle as appropriate.

Yes No

Please provide details and dates below:

……..

……

SECTION C - FAMILY HEALTH HISTORY: Circle to indicate any occurrence of the following:

Alcoholism
Allergies
Arthritis
Asthma
Cancer
Diabetes
Emotional health issues
Epilepsy
Heart Disease
High Blood Pressure
Kidney disease
Rheumatic Fever
Tuberculosis

SIGNATURE: ……

RELATIONSHIP TO THE CHILD:…… **DATE**: ……..

Pre Admission Medical Form (PAMF) updated May 2018.