CEDAR INTERNATIONAL SCHOOL
BRITISH VIRGIN ISLANDS

# *Health Form*

Name of Student _____ Date of Birth_____

Parent / Guardian Name _____Tel: _____

Physician Name and Address _____ Tel: _____

_____

**Please provide details if YES applies;**

Epilepsy / seizure disorder Y / N _____Medication_____

Asthma Y / N _____ Medication_____

Allergies Y / N_____ Medication_____

Diabetes Y / N_____ Medication_____

Cardiac condition Y / N_____ Medication_____

Other Y / N_____

Significant family health history Y / N_____

Previous operations /surgery Y/ N_____

Other medications Y / N_____

**Please complete fully OR provide a photocopy of the immunisation record.**

| Vaccine | Initial (infant) | Second (infant) | Third (infant) | First Booster | Second Booster | Third Booster |
|---|---|---|---|---|---|---|
| DTP or DT<br>Diphtheria<br>Tetanus<br>Pertussis | | | | | | |
| Polio | | | | | | |
| MMR<br>Mumps<br>Measles<br>Rubella | | | | | | |
| BCG<br>(Tuberculosis) | | | | | | |
| Hib<br>H.influenza<br>Type B | | | | | | |
| Hepatitis B | | | | | | |
| Other | | | | | | |

**Physical Examination by physician.**

| Date | | Comments |
|---|---|---|
| Height | | |
| Weight | | |
| Vision<br>w/glasses | Right<br>Left | |
| Vision<br>w/o glasses | Right<br>Left | |
| Hearing | | |
| ENT | | |

| | | |
|---|---|---|
| Heart | | |
| Lungs | | |
| Breasts | | |
| Abdomen | | |
| Genitalia | | |
| Muscular-Skeletal | | |
| Posture & Feet | | |
| Skin | | |
| Speech | | |

Comments and Recommendations from Physician (with date and authorising stamp):

Is this child fit and healthy Y / N  Physician's Stamp/Seal _____

Physician's Signature _____ Date _____