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 Diphtheria Tetanus Pertussis						
Polio						
MMR Mumps Measles Rubella						
BCG (Tuberculosis)						
Hib H.influenza Type B						
Hepatitis B						
Other						

Physical Examination by physician.

Date		Comments
Height		
Weight		
Vision w/glasses	Right Left	
Vision w/o glasses	Right 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 _____