SABIS® SUN International School
Dreamland - Baku, Azerbaijan

Medical Form

First Name: _____

Father's Name: _____

Family Name: _____

Date of Birth: _____

Grade: _____

1- Does your child currently take any medication?

Yes ◯ No ◯

If yes, please specify: why, dose and frequency _____

2- Has your child ever been hospitalized?

Yes ◯ No ◯

If yes, please specify, when and what for? _____

3- Is there a history of color blindness in your family or any other visual problems?

Yes ◯ No ◯

If yes, please explain _____

(If yes, kindly submit an up-to-date medical report)

4- Does your child have speech problems?

Yes ◯ No ◯

If yes, please explain _____

(If yes, kindly submit an up-to-date medical report)

5- Does your child have difficulty in hearing?

Yes ◯ No ◯

If yes, please explain _____

(If yes, kindly submit an up-to-date medical report)

6- Do you have any objection to the school doctor/nurse examining your child?

Yes ◯ No ◯

7- Does your child suffer from any of the following conditions?

Medical condition	Yes	No	Medication
Asthma			
Diabetes			
Epilepsy			
Hay fever			
Tuberculosis			
Eczema			
Heart disease			

Others, please explain: _____

_____

8- Does your child have any allergies?

Allergen

Eggs	Peanuts	Sea Food	Wheat	Insects
Latex	Medication	Dairy Products	Fruits	Others

Please specify: _____

Reaction

Eczema	Rash	Hives	Eye swelling	Hoarse voice
Mouth swelling	Wheezing	Vomiting/diarrhea	Passing out	Others

Please specify: _____

Intervention needed

None	ER visit	Medication	Hospitalization	Others

Please specify: _____

9- Has your child had any of the following inoculations?

If yes, please fill in the date of the last vaccine.

Vaccine	Date of last taken vaccine
BCG	/
Hepatitis B	/
MMR (measles, mumps, rubella)	/
Chicken Pox / Varicella	/
DPT (diphtheria, tetanus, pertussis)	/
Polio (OPV)	/
HIB (haemophilus influenza)	/
DT (diphtheria, tetanus)	/
Rotarix	/
Hepatitis A	/
Meningitis	/
Typhoid	/
Other: please specify	

(Kindly attach a copy of the vaccination card)

10- Has your child suffered from any of the following illnesses?

Disease	Yes	No	Year
Measles			
Mumps			
German Measles			
Chicken Pox			
Tuberculosis			
Whooping Cough			
Other: please specify			

11- In case of accidents or other emergencies, give three sources to be contacted:

If these sources cannot be contacted, the student will be taken to the nearest hospital.

If your child is to be administered a medication from your doctor during school hours, the medicine should be given to the school nurse first thing in the morning with an accompanying letter from the parents or doctor. The medicine can be then collected from the clinic at the end of the school day. Please clearly write the child's name, class, time, and dose of the medication. Medicines are not to be kept with children.

I Mr./Mrs _____, parent of the student _____, hereby certify that the information provided in this form is true and assume responsibility for any missing health-related information (illness and/or allergy). I shall be responsible for and shall release and indemnify the school and its employees from and against all liability arising from all illnesses or allergies my child has and the consequences that might result.

I understand that any false or misleading information or significant omissions may entitle the school to reconsider my child's attendance at school.

I agree to immediately notify the school should any illnesses develop.

Parent's Name _____

Parent's Signature _____

Provider's Signature _____

Date _____

For School Use.

Remarks _____

_____

_____

_____

_____

Date checked: ____ / ____ / _____ Dr./Nurse Signature: _____