Medical Record

Name of the Student:____

Date of Birth (dd/mm/yy): ____________________ Blood Type: ____________ Height: __________ Weight: ________

Name of the Doctor: ____________________________ Name of the Hospital: ________________________________

Doctor's Cell Phone: __________________Doctor's Beeper__________________ Doctor's Office: ________________

1. Does the student take any medication? If so, please list:

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2. Describe any important health related information about the child:

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3. Does the student suffer from Asthma or has any allergic reaction to a medicine, food, bee stings, or another substance? :

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4. Has the student been vaccinated? If so, please list:

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5. Does the student require special assistance at school? If the answer is yes, please explain.

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___________________________ ___________________________

Doctor's Signature Date (dd/mm/yy)