HEALTH QUESTIONNAIRE

PERSONAL INFORMATION

NAME ____________________ M ☐ F ☐ DATE OF BIRTH_______________

NATIONALITY ______________________

ADDRESS ____

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TELEPHONE _______________________ EMAIL ___________________________________

MEDICAL IFNORMATION

Does the student suffer from any of the following?

Asthma	☐	Rheumatism	☐
Epilepsy	☐	Diabetes	☐
Heart problems	☐	Tuberculosis	☐
Skin problems	☐	Psychological problems	☐
Other	☐		

Comments ____

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Has the student had any surgery? Yes / No

If yes, please give details including dates.

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Does the student have any known allergies to food, medicine or other (eg: bee stings)? Yes / No

If yes, please give details.

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Does the student have any regular medication? Yes / No

If yes, please give details including the prescribing doctor's name and dosage.

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VACCINATIONS (Please attach a copy of the vaccination certificate)

		Date			Date
Diphtheria	☐	_______________	Mumps	☐	_______________
Tetanus	☐	_______________	German measles	☐	_______________
Poliomyletis	☐	_______________	Whooping cough	☐	_______________
Tuberculosis	☐	_______________	Typhoid	☐	_______________
Measles	☐	_______________	Hepatitis A	☐	_______________
			Hepatitis B	☐	_______________

I declare the above information to be correct.

Date ____________Signature of physician ___________________ Parent signature _______________

Physician's seal