

**AJIS Admission Form**

**Student Medical Form**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Year/Section\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is the student currently taking any medication? Yes No

If yes, please specify: why, dose and frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has the student ever been hospitalised? Yes No

If yes, please specify, when and what for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the student have speech problems? Yes No

If yes, please explain and submit a current Medical Report\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the student suffer from hearing problems? Yes No

If yes, please explain and submit current Medical Report\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the student suffer from vision problems? Yes No

If yes, please explain and submit current Medical Report\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your child suffer from any of the following conditions?

|  |  |  |  |
| --- | --- | --- | --- |
| **Illness** | **Yes** | **No** | **Details** |
| Asthma |  |  |  |
| Diabetes |  |  |  |
| Epilepsy |  |  |  |
| Hay fever |  |  |  |
| Tuberculosis |  |  |  |
| Eczema |  |  |  |
| Heart Disease |  |  |  |

1. Please Tick if your child has any allergy

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PEANUTS |  | EGG |  | SEA FOOD |  | WHEAT |  | FRUITS |  |
| LATEX |  | MEDICATION |  | DAIRY PRODUCTS |  | INSECTS |  | OTHERS |  |

If OTHERS Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please Tick what kind of reaction might occur

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| RASH |  | HIVES |  | PASSING OUT | MOUTH SWELLING |  | WHEEZING |  |
| VOMITING |  | DIAREHAA |  | HOARSE VOICE | ITCH |  | OTHERS |  |

If OTHERS Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please indicate intervention needed.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| NONE |  | ER VISIT |  | HOSPITALIZATION |  | OTHERS |  |

If OTHERS Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please Fill in the date of last vaccine administered

|  |  |
| --- | --- |
| **Vaccine** | **Tick if Taken** |
| BCG Bacillus, Calmette-Guerin (against tuberculosis) |  |
| DPT/ DTaP/ Tdap Diphtheria, Pertussis and Tetanus |  |
| Hep B Hepatitis B |  |
| Hib Haemophilus Influenzae Type B |  |
| OPV/ IPV Oral Poliovirus Vaccine/ Inactivated Poliovirus Vaccine |  |
| HPV Human Papillomavirus |  |
| PCV Pneumococcal Conjugate Vaccine |  |
| MMR Measles, Mumps and Rubella |  |
| Chicken Pox/Varicella |  |
| Rotarix |  |
| Rubella |  |
| Others: Please specify |  |

(Kindly attach a copy of the Vaccination card)

1. Please indicate if your child has suffered from any of the following illnesses.

|  |  |  |  |
| --- | --- | --- | --- |
| **Illness** | **Yes** | **No** | **Date of the illness** |
| Covid 19 |  |  |  |
| Measles |  |  |  |
| Mumps |  |  |  |
| German Measles |  |  |  |
| Chicken Pox |  |  |  |
| Tuberculosis |  |  |  |
| Whopping Cough |  |  |  |
| Other, please specify |  |  |  |

1. Please insert 3 persons to be contacted in case of accidents or emergency.

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relation to family | Mobile number | Land Line number |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

If the above persons cannot be contacted the student will be taken to the nearest hospital according to the signed consent form.

1. Students are not allowed to keep any medicines in the classroom for safety reasons. If any prescribed medication requires administration during schools hours, then the student must be sent to the school clinic with the prescription from the doctor stating the time and the dose required. The school nurse will administer “short term” medications. Please refer to the “Medication in School” information section on the AJIS webpage under “Clinic”

If the student is using the school’s transport, you can give the medicine and the prescription to the bus attendant.

1. If your child has any of the following they must be free of the symptom for 24 hours before they return to school.

Vomiting /Diarrhea /Fever/Inflamed throat/Persistent cough/Unexplained rash. (children should return to school with a doctor certificate if the child has an unexplainable rash.

1. Please note that the school must be provided with the treatment/family doctor’s clearance certificate before your child can resume classes if he suffered from any viral illness/sore eyes (conjunctivitis) /chicken pox/mumps/measles etc. Please refer to the “returning to school after a sick period” information section on the AJIS webpage under “Clinic”
2. Please be aware that AJIS is a nut free school. Please ensure your child is provided a nut free food/snacks. Any birthday/celebration treats brought into the school must be nut free. Please refer to the “School Nut Free Policy” information section on the AJIS webpage under “Clinic”
3. It is mandatory for parents to disclose any medical condition/allergy/sickness their child may suffer.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Parent of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Year/ Section \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Herby certify that all the above information is true and accurate and I take full responsibility for any missing, false or misleading information about my child health condition and allergy and I release AJIS and its employee from any liability arising from the consequences of illnesses and allergies.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_