PAKISTAN INTERNATIONAL SCHOOL

DOHA, QATAR

STUDENT MEDICAL HISTORY FORM

Dear Parent/ Guardian:

Kindly fill this form about the Medical History of your Son / Daughter by answering **YES** or **NO.** If any answer is YES, please provide us with dates and details. Answers should be as accurate as possible. The Student's Health is our priority.

Student's data:

Student's Full Name: _____

Gender: MALE: _____ **FEMALE:** _____ **Nationality:** _____

Date of Birth: _____ **Grade & Class:** _____

Guardian's Name: _____ **Relation to Student:** _____

Contact Number: _____**Religion**: _____

Address:

_____

Required Documents:

Attached

- **Passport Copy:** **YES** _____ **No** _____
- **QID card Copy:** **YES**_____ **No** _____ **QID No**. _____
- **Health Card Copy:** **YES** _____ **No** _____ **HC No:** _____

No.	Health Concerns	YES	NO	COMMENTS
1.	Does the student have any allergy or sensitivity to medication, food, etc.? Please mention it if any_____			
2.	Does the student suffer from any cardiac problems / Heart problems?			
3.	Is the student Diabetic?			
4.	Does the student have hypertension?			
5.	Is the student Asthmatic?			
6.	Does the student suffer from any Renal Problem (Kidney Problem)?			
7.	Did the student suffer previously from Urinary Tract Infections?			
8.	Does the student suffer from Epilepsy or Seizures?			
9.	Is the student suffering from G6PD deficiency?			
10.	Does the student have any Chronic Blood Disease? (Thalassemia, Anemia, Hemophilia, etc.?)			
11.	Does the student suffer from recurrent epistaxis or nasal bleeding?			
12.	Does the student have any eye problems?			
13.	Does the student have any skin problem?			
14.	Any previous surgical procedure done?			
15.	Any previous admissions to Hospital? Please mention			
16.	Is the student using hearing / visual / walking aids? If Yes, what is it?			
17.	Did the student ever get mumps, measles, and chicken pox?			
18.	Does the student suffer from any psychiatric / behavioral problems?			

Long Term medication used by the Student:

Name of Medication: _____ **Dose & Frequency:** _____

Medication recommended in case of emergency:_____

Dietary recommendations: _____

Physical Activity Recommendations: _____

Recommendation for the School Nurse during the School Hours:

_____

Parent's / Guardian's Signature: _____ **Date**: _____