



Student Health Record

Student's Name: _____ Class: _____

Date of Birth: _____ CPR No.: _____ Male / Female

* Please fill out the form in English only.

Please tick or indicate the diagnosed illness of your child:

Health Condition	YES	NO
Asthma		
Chicken Pox		
Diabetes		
Ecsema		
Epilepsy		
G6PD		
Hepatitis		
Measles		
Mumps		
Persistent Headache		
Sickle Cell Disease		
Others (Please Specify):		

Is your Child allergic to any medicine, food or product?

Medicines	YES	NO
Paracetamol		
Peanuts		
Others (Please Specify):		

Is your child taking any regular medication or receiving any regular medical treatment?

Medicines	YES	NO
Inhalers		
Insulin		
Others (Please Specify):		



Can the School give one of the following medication to your child if necessary?

Medicines	YES	NO
Brufen		
Buscopan		
Margadoosh		
Paracetamol / Panadol		
Scopinal		
Others (Please Specify):		

State the help that we can do with your child while he / she is in School Premises in case of emergency?

Please Provide us your Contact Numbers in Case of an Emergency:

Father's Mobile Number: _____
Mother's Mobile Number: _____
Emergency Numbers: _____
Other Relatives Number: _____

I, the parent / guardian of _____
Confirm that I have stated the required information regarding my child's health, that APG School is responsible in case of not stating any illness. Moreover, I have given my permission to APG School to help my child and look after him / her whenever needed. In addition, I have attached my child's Medical Report from his / her Attending Physician / Doctor for more details.

Parent / Guardian's Full Name: _____ Signature: _____
Date: _____