MEDICAL & HEALTH INFORMATION

Student's Name: _____
Birth Date: _____ Blood Type: _____
Height (cm) _____ Wt (kl) _____

MEDICAL HISTORY
Has the child suffered from any of the following in the last two years?

	NO	YES	DATE (month & year)
1. Asthma			
2. Allergy			
3. Epilepsy / Convulsions			
4. Chicken Pox			
5. Primary Complex / TB			
6. Measles			
7. COVID-19			
8. Dengue			
9. Influenza (flu)			
10. Depression			

Indicate the vaccination and booster dates for the following diseases. Mark with ***X*** if not yet given.

	1st	2nd	Booster
1. MMR (Measles, Mumps, Rubella)			
2. Varicella (Chicken Pox)			
3. TD (Tetanus Diptheria)			
4. Pneumococcal (Pneumonia)			
5. Typhoid			
6. BCG (Tuberculosis)			
7. COVID-19			
8. Influenza (flu)			

Form completed by: _____ License No. _____

Date: _____