



KINGS WAY PRIMARY SCHOOL - KALONGO

Kalongo Town Council, Agago District(Uganda)

Telephone:

Director: +256-772 511 720

Head teacher: +256-772 157 140/+256-775 888 810

School Medical Form

Student Information:

Full Name: _____

Date of Birth: _____

Gender: Male Female Other

Grade/Class: _____

Parent/Guardian Name: _____

Relationship to Student: _____

Phone Number: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Medical History:

1. Does your child have any known allergies?

Yes No

If yes, please list: _____

2. Does your child have any chronic illnesses or conditions?

Yes No

If yes, please specify: _____

3. Has your child had any surgeries or hospitalizations?

Yes No

If yes, please describe: _____

4. Is your child currently taking any medications?

Yes No

If yes, please list medications: _____

5. Does your child have any special dietary restrictions?

Yes No

If yes, please specify: _____

6. Other health concerns or relevant medical information:

Immunization Record:

Date of Last Tetanus Shot: _____

Date of Last Flu Shot: _____

Other Vaccinations: _____

Consent:

I, the undersigned, give permission for my child to receive necessary medical treatment in case of an emergency while at school. This includes any medical treatment deemed necessary by the school nurse or authorized personnel.

Parent/Guardian

Signature: _____

Date: _____

Notes: Please ensure all information is filled out accurately. The information provided will be kept confidential and only used in the case of a medical emergency. Return this form to the school office by the office by: _____