** BRITISH INTERNATIONAL SCHOOL RIYADH **

[**www.bisr.com.sa**](http://www.bisr.com.sa)

**MEDICAL REPORT**

***Mandatory requirement prior to admission***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Child’s Family Name: | | | | Child’s First Name: | | | |
| Girl / Boy | Date of Birth (day/month/year): | | | | | | |
| Home Address: | | | | | | Home Phone: | |
| Father’s Name: | | Occupation: | | | | Work Phone: | |
| Mother’s Name: | | Occupation: | | | | Work Phone: | |
| Emergency Contact Name: | | | | | Contact Numbers: / | | |
| Mobile Numbers: Father: | | | Mother: | | | | Emergency: |

|  |  |  |
| --- | --- | --- |
| **CONSENT TO TREATMENT BY SALWA STAFF**  I consent to my child receiving the necessary treatment and/or first aid from the Salwa staff. | | |
| Print Name: | Signature: | Date: |

|  |  |  |
| --- | --- | --- |
| **CONSENT TO INITIAL CARE BY THE SALWA MEDICAL CENTRE**  I consent to arrangements being made, in an emergency, for my child to receive initial treatment from the Salwa Medical Centre and the 24 hour policy. | | |
| Print Name: | Signature: | Date: |

|  |
| --- |
| Does your child have any special medical problems? |
| Does your child take medication regularly? Yes / No If yes, please give details: |
| Is your child allergic to anything, including medication? Please give details: |

**Please update the clinic regarding new or changes to any health issues**

**Please complete the ‘HEALTH HISTORY’ below and ask your doctor to complete the “MEDICAL REPORT’ when he examines your child.**

**HEALTH HISTORY**

**To be completed by parent and reviewed by family physician**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Mandatory** | **Immunization Dates** | | | **Pre-School Booster** | **10 – 14 years** |
|  | **1st** | **2nd** | **3rd** | **4-5 years** |  |
| **Diptheria, Pertussis & Tetanus (DPT)** |  |  |  |  |  |
| **Polio (Drops)** |  |  |  |  |  |
| **Mumps, Measles & Rubella (MMR)** |  |  |  |  |  |
| **Rubella (German Measles) *Girls only*** |  |  |  |  |  |
| **Tuberculin Skin Test (M)** | Date: | | Pos: | Neg: |  |
| **BCG Vaccination** | Date: | |  |  |  |

**Recommended Immunization**

|  |  |
| --- | --- |
| **Hepatitis** | Date: |
| **Meningitis** | Date: |

Has your child had any of the following (tick applicable box) and write any further comments below or attach a letter giving full details.

|  |  |  |
| --- | --- | --- |
| Chicken Pox | Measles | Athletes Foot |
| Hepatitis | Meningitis | Verruca |
| Heart Condition | Migraine | Diabetes |
| Eczema | Coordination Problems | Orthopedic Problems |
| Vision / Eye Problems | Hearing / Ear Problems | Epilepsy / Convulsions /Seizures |
| Speech Difficulties | Concentration Problems | Behavioral Problems |
| Hospitalisation and/or operations: | | |
| Asthma: takes medication? Yes/No. If yes, please supply an inhaler/medication to be kept in the school clinic for  routine/emergency use. | | |
| Any other relevant medical information: | | |

Is there anything the school should know regarding your child’s health that is not mentioned on this form? If so, please state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your child is to be administered medication from your doctor during school hours, it will only be given with an accompanying letter from the parents or doctors. If you give your child medicine before he/she comes to school **please** inform the Salwa staff.

**MEDICAL REPORT**

**To be completed by family physician**

History (Please review parent’s history and make any pertinent additions). Current immunization for: diphtheria, tetanus, poliomyelitis, tuberculosis skin test and BCG (if indicated – TB is prevalent here), hearing (audiometry), vision tests.

|  |  |  |
| --- | --- | --- |
| Child’s Family Name: | Child’s First Name | Age: |
| Date of examination (day/month/year): | | |

**Physical Examination**

|  |  |  |
| --- | --- | --- |
| Height: | Weight: | Development: |
| Eyes: Vision (with/without) spectacles Right: Left: | | |
| Ears: Hearing (Audiometry) Right: Left: | | |
| *Please attach copies of investigation reports where possible* | | |

Based on current history and physical examination, I find the above named student free of contagious disease, vaccinated in accordance with the above mandatory school requirements and for all usual school activities.

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**Doctor’s Signature (include physician / clinic stamp) Date**

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**Parent’s Signature**