London Islamic School

# Student Health Record

## 2014-2015

Student's Name: _____ Date of Birth: _____

Place of Birth: _____ Health Card #:_____

Family Doctor: _____ Family Doctor's Phone #:_____

Father's Name: _____ Mother's Name: _____

Address: _____ Telephone: _____

Does your child have any chronic disease or other health problems that the administration needs to be aware of, or that may interfere with emergency medical treatment?

☐ No ☐ Yes If yes, please specify: _____

_____

Does your child have any food or medical allergies?

☐ No ☐ Yes If yes, please specify: _____

_____

Does your child take any medication on a regular basis?

☐ No ☐ Yes If yes, please specify: _____

_____

_____

Has your child had any of the following diseases?

| | | |
|---|---|---|
| ☐ Mumps | ☐ Diphtheria | ☐ Tuberculosis |
| ☐ Red Measles | ☐ Poliomyelitis | ☐ Hepatitis |
| ☐ German Measles | ☐ Whooping Cough | ☐ Chicken Pox |

Does your child have or has he/she had any of the following medical conditions?

| | | | |
|---|---|---|---|
| ☐ Asthma | ☐ Headaches | ☐ Constipation | ☐ Heart Trouble |
| ☐ Urinary Disorder | ☐ Fainting | ☐ Diabetes | ☐ Ear Aches Skin |
| ☐ Disorder | ☐ Convulsions | ☐ Stomach Aches | ☐ Eating Disorder |

*By signing this health record, you are giving permission to the London Islamic School to release this medical information to the necessary medical emergency personnel if the need arises.*

Parent's Name: _____ Parent's Signature: _____Date: _____