LITTLE WORLD INTERNATIONAL SCHOOL

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HEALTH FORM

Student's Name: _____ 1

Date of Birth: _____ (DD/MM/YY) 1

Photograph

Emergency Contact:

Name: _____ 1

Emergency Tel. No.: _____ Residence: _____ 1

Mobile: _____ E mail: _____ 1

Does your child suffer from any of the following (PLEASE CHECK). If the answer is **YES** please provide details:

Diabetes	**YES** ☐	**NO** ☐		**Asthma**	**YES** ☐	**NO** ☐	
Epilepsy	**YES** ☐	**NO** ☐		**Convulsions**	**YES** ☐	**NO** ☐	
Eyesight difficulties	**YES** ☐	**NO** ☐		**Hearing Difficulties**	**YES** ☐	**NO** ☐	

Does your child take regular medications?

Diabetes	**YES** ☐	**NO** ☐

Has your child ever had any of the following diseases?

German Measles	**YES** ☐	**NO** ☐		**Measles**	**YES** ☐	**NO** ☐	
Mumps	**YES** ☐	**NO** ☐		**Meningitis**	**YES** ☐	**NO** ☐	
Chicken Pox	**YES** ☐	**NO** ☐		**Hepatitis**	**YES** ☐	**NO** ☐	
Glandular Fever	**YES** ☐	**NO** ☐					

Please indicate last inoculations administered to your child:

Polio / Tetanus / Diphtheria: _____ (DD/MM/YY)

Measles: _____ (DD/MM/YY)

German Measles: _____ (DD/MM/YY)

BCG: _____ (DD/MM/YY)

Any other information which you would like us to know about your child:

_____ (DD/MM/YY)