



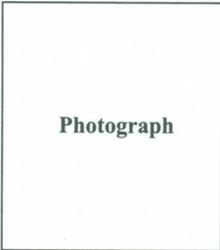
# LITTLE WORLD INTERNATIONAL SCHOOL

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## HEALTH FORM

Student's Name: \_\_\_\_\_ 1

Date of Birth: \_\_\_\_\_ (DD/MM/YY) 1



### 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 | <input type="checkbox"/> | NO | <input type="checkbox"/> | Asthma               | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Epilepsy              | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | Convulsions          | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Eyesight difficulties | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | Hearing Difficulties | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

Does your child take regular medications?

Diabetes YES  NO

Has your child ever had any of the following diseases?

- |                 |     |                          |    |                          |            |     |                          |    |                          |
|-----------------|-----|--------------------------|----|--------------------------|------------|-----|--------------------------|----|--------------------------|
| German Measles  | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | Measles    | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Mumps           | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | Meningitis | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Chicken Pox     | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | Hepatitis  | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| Glandular Fever | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |            |     |                          |    |                          |

*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)