



Student's medical questionnaire

John F. Kennedy International School, 8 Chilchgasse, 3792 Saanen, Switzerland.

Thank you for your cooperation. **It is very important that a correct reply be given to all sections.**

Name: _____

First name: _____

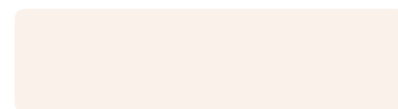
Sex F ☐ M ☐ Date of birth: _____ Blood group: _____

Contact person / Phone number in case of emergency: _____

Address _____

I am the parent/guardian of the student named above. I give permission for the information of this form provided about my child to be reviewed and utilized by the doctors, directors and any school personnel providing school health services, for the limited purpose of meeting my child's health and educational needs.

Place and date: _____ Signature (parent or guardian):



Student's Health Insurance Company:

Policy Number:

Please provide the school with a copy of the medical insurance card which covers your child/children of all medical and accidents during their school term.

SECTION I –STUDENT'S MEDICAL HISTORY

Has he/she, or does he/she suffer(ed) from:

- | | | | |
|--|--|---|--|
| • Any concerns about nutrition, eating habits, weight etc. | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Diabetes (if yes, state type) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any trouble with sleeping habits | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ | |
| • Any allergies (food, insects, medication etc.) | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Any orthopedic trouble | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any social, emotional or behavioural problem | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Epilepsy | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any problem with vision, hearing or speech | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Any heart trouble (heart murmur etc.) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any significant accidents or injuries | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Any recurrent illnesses (tonsillitis, headaches etc.) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any lung problems/asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Any skin problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any concerns about kidneys or uro-genital system | <input type="checkbox"/> YES <input type="checkbox"/> NO | • Others | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| • Any learning differences (e.g. dyslexia or other) | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ | |

Please explain any "Yes" answers from above. (Nature and frequency of the trouble, last episode, intensity etc.)

SECTION II - PAST ILLNESSES Please check the correct response, and give date if possible:

	Date		Date
• Mumps	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• German measles	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
• Scarlet Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Whooping cough	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
• Chickenpox	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Diphtheria	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
• Measles	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Pneumonia	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
• Other	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	(Mononucleosis, tuberculosis, typhoid, malaria, Pfeiffer etc...)	

SECTION III - GENERAL ISSUES

Has the student ever spent time in hospital or undergone surgery? If so, give details.

☐ YES ☐ NO _____

Does the student take medication regularly or occasionally? If so, which and for what reason?

☐ YES ☐ NO _____

Is there any reason that the student may not participate fully in school activities, including physical education? If yes, give the reason, and the necessary restriction/adaptation:

☐ YES ☐ NO _____

Does your child follow any psychological or psychiatric treatment? If so, please give details:

☐ YES ☐ NO _____

Should my child be injured or become ill while attending the John F. Kennedy School, I expect the school authorities to see that he/she is attended to by qualified medical or dental practitioners, and I authorise the school to act on my behalf in arranging whatever treatment appears necessary.

☐ YES ☐ NO

SECTION IV - VACCINATIONS Please check the correct response and give date if possible:

	Date		Date		Date
• Hepatitis A+B Twinrix	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Tetanus	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Booster	<input type="checkbox"/> YES <input type="checkbox"/> NO _____
• Hepatitis A	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Poliomyelitis	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	Type of vaccine	_____
• Hepatitis B	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Diphtheria Tetanus-Whooping cough (Di-Te-Per)	<input type="checkbox"/> YES <input type="checkbox"/> NO _____		_____
• Tuberculosis BCG	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Diphtheria Tetanus-Polio (Di-Te-Pol)	<input type="checkbox"/> YES <input type="checkbox"/> NO _____		_____
• Tuberculin test	<input type="checkbox"/> YES <input type="checkbox"/> NO _____				
	<input type="checkbox"/> Successful <input type="checkbox"/> Unsuccessful				
• Other vaccinations	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	Type of vaccine(s)	_____		
• Serums	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	Type	_____		
(e.g. anti-tetanus)					



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SECTION V – PHYSICIAN'S ANALYSIS (only for new students or change of circumstances)

On the basis of the child's history, physical examination and other data, the following statement is applicable: **(please check)**

- ☐ This child is in excellent health and no significant abnormalities are noted.
- ☐ This child is in good health, but the following abnormalities should be noted:

Date: _____

Signature and stamp of Physician: _____

Name, Address and phone number of Physician:
