

## Health History

Please fill in the application form below:

### Pupil's Data

Full name of pupil:

Date of Birth:

Gender:

### General Data

Your Name:

Your Email Address:

### Person to be contacted if parents unavailable...

Name:

Address:

Telephone:

### Please state below previous infectious Diseases if any

Disease	Year	Complications
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

### Please indicate if your child has had any of the following health problems:

- Accidents/Burns:  Yes  No If 'Yes', specify:
- Allergies. Food/Environmental  Yes  No If 'Yes', specify:
- Allergies to medicines  Yes  No If 'Yes', specify:
- Bronchial Asthma:  Yes  No If 'Yes', specify:
- Chest / heart disease  Yes  No If 'Yes', specify:
- Dental problems:  Yes  No If 'Yes', specify:
- Diabetes:  Yes  No If 'Yes', specify:
- Ear problems:  Yes  No If 'Yes', specify:

Epilepsy:	<input type="radio"/> Yes <input type="radio"/> No	If 'Yes', specify: <input type="text"/>
Fractures:	<input type="radio"/> Yes <input type="radio"/> No	If 'Yes', specify: <input type="text"/>
Head injury:	<input type="radio"/> Yes <input type="radio"/> No	If 'Yes', specify: <input type="text"/>
Neurological disease:	<input type="radio"/> Yes <input type="radio"/> No	If 'Yes', specify: <input type="text"/>
Renal (kidney) disease:	<input type="radio"/> Yes <input type="radio"/> No	If 'Yes', specify: <input type="text"/>
Surgery:	<input type="radio"/> Yes <input type="radio"/> No	If 'Yes', specify: <input type="text"/>
tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	If 'Yes', specify: <input type="text"/>
Vision defects:	<input type="radio"/> Yes <input type="radio"/> No	If 'Yes', specify: <input type="text"/>
Do you permit the school nurse to administer non-prescriptive medication to your child (e.g. Paracetamol, cough syrup)? Y/N:	<input type="radio"/> Yes <input type="radio"/> No	