



HORIZON PRIVATE SCHOOL - Branch

MEDICAL RECORD

Name of Student: _____ Date of Birth: _____

- Does your child have any allergies to medications? If yes, please specify.

- Does your child have any food allergies? If yes, please specify.

- Does your child have any serious medical conditions such as diabetes, hypoglycemia, epilepsy, asthma, etc.? If yes, please specify.

- Does your child have hearing problems? _____

- Does your child have sight problems? _____

- Has your child ever undergone a major surgery? If yes, please specify.

- Does your child take regular medication? If yes, please specify.

- Do you give the school permission to give your child panadol in case of minor headache or pain? If yes, please specify the dosage and the type of panadol (syrup or tablets).

- Name of family clinic or doctor: _____

- Emergency contacts:

NAME: _____ NUMBER: _____

NAME: _____ NUMBER: _____

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____