

# MEDICAL CERTIFICATE

**Please have the following certificate completed, signed and stamped by your doctor and returned to the school**

Students are not allowed to keep medication in their rooms. The school has a stock of all basic medications necessary for treating students with minor injuries or illnesses.

All medicines brought by students will be stored with the school supervisors until the day of their departure. Students who are required to take a daily dose must come to the supervisor in charge.

The school work closely with local doctors and specialists.

**It is very important that a correct reply be given to all sections**

Family name: \_\_\_\_\_

First name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

**PART I - STUDENT'S MEDICAL HISTORY (to be filled in by the parents)**

Height: \_\_\_\_\_ cm      Weight: \_\_\_\_\_ kg      Blood group: \_\_\_\_\_

Visual perception:       Glasses       Contact lenses      Details: \_\_\_\_\_

Has your daughter or does your daughter suffer (ed) from:

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

Please explain any "Yes" answers from above:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Childhood illnesses**

- |                 |                              |                             |                 |                              |                             |          |
|-----------------|------------------------------|-----------------------------|-----------------|------------------------------|-----------------------------|----------|
| • Measles.      | <input type="checkbox"/> YES | <input type="checkbox"/> NO | • Chickenpox    | <input type="checkbox"/> YES | <input type="checkbox"/> NO | • German |
| measles         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | • Mumps         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |          |
| • Scarlet fever | <input type="checkbox"/> YES | <input type="checkbox"/> NO | • Mononucleosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |          |

**PART 2 - GENERAL ISSUES**

Food requirements for religious reasons

- vegetarian with eggs     YES     NO    vegetarian without eggs     YES     NO  
 no pork/no alcohol     YES     NO    no beef/no veal     YES     NO

Has the student ever spent time in hospital or undergone surgery? Please specify.

YES  NO \_\_\_\_\_  
 \_\_\_\_\_

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

YES  NO \_\_\_\_\_  
 \_\_\_\_\_

Does your daughter follow/has your daughter followed any psychological or psychiatric treatment? If so, please give details:

YES  NO \_\_\_\_\_  
 \_\_\_\_\_

**PART 3 - VACCINATIONS**

Please check the vaccinations she has had and give date if possible:

- Hepatitis A+B Twinrix     YES     NO \_\_\_\_\_
- Hepatitis A     YES     NO \_\_\_\_\_
- Hepatitis B     YES     NO \_\_\_\_\_
- Poliomyelitis     YES     NO \_\_\_\_\_
- Tuberculosis BCG     YES     NO \_\_\_\_\_
- Other vaccinations \_\_\_\_\_
- Tetanus     YES     NO \_\_\_\_\_
- Diphtheria     YES     NO \_\_\_\_\_
- Pertussis     YES     NO \_\_\_\_\_
- Type of vaccine \_\_\_\_\_
- Type of vaccine \_\_\_\_\_

**TO BE FILLED IN BY THE DOCTOR**

Miss \_\_\_\_\_

- is in good mental and physical health.
- has not been in recent contact with anyone suffering from a contagious disease.
- should be under observation for the following:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Place and date: \_\_\_\_\_

Doctor's stamp and signature:

I am the parent/guardian of the student named above and confirm that all information given by my daughter's doctor is correct.

Survall Mont-Fleuri can, under no circumstances, be held responsible for any problems which could occur and have not been mentioned in this medical certificate

Place and date: \_\_\_\_\_

Signature parent/guardian: \_\_\_\_\_