MEDICAL RECORDS

HEALTH INFORMATION

Full Name of the Child (Surname first)

Date of Birth

Weight at birth

Mode of Delivery:

Cesarean section ☐ Vaginal delivery ☐

Was your child premature? Yes ☐ No ☐

Other information:

List all prescriptions and over-the-counter medications taken regularly by your child.

Name and address of your child's clinic.

Does your child visit a dentist regularly? Yes ☐ No ☐

If yes, date of last appointment

Has your child undergone any major operation and hospitalizations? (If yes, please provide details and date)

Does your child has any allergy? Please give details.

Are there other important health information we need to know? Please specify.

Does your child use any of the following?

Glasses/Contact Lenses ☐ Hearing Aid ☐ Dentures/braces Inhaler ☐

Blood group ☐ Genotype ☐ Rhesus factor ☐

CHRONIC, RECURRING AND SPECIAL HEALTH CONDITIONS

(Please tick the relevant boxes if your child has any of the following conditions)

	Yes	**No**
Autism	☐	☐
Asthma	☐	☐
Attention – Deficit Hyperactivity Disorder	☐	☐
Behavioural or Developmental Challenges	☐	☐
Dental Challenges	☐	☐
Diabetes	☐	☐
Hearing Impairment	☐	☐
Heart Disease	☐	☐
Kidney Disease	☐	☐
Seizures	☐	☐
Sickle Cell Disease (not trait)	☐	☐

Visual Impairment	☐	☐
Hemophilia	☐	☐
Others. Please specify.		

Does your child has any condition that requires any medical support? Please specify

1. Type of condition:
   _____
2. Educational support needed:
   _____
3. Environmental adjustment:
   _____
4. Activity limitation (if any):
   _____
5. Assessment carried out by:
   _____
6. Recommendations and referrals made, if any

Physician's name: _____

Address: _____

Phone number: _____

I hereby certify that all the information provided by me is true and correct.

Mother's Name: _____ Father's Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____