



# JUST KIDS ACADEMY STUDENT MEDICAL FORM



## PARENT SECTION

Child's Full Name: \_\_\_\_\_

Parent /Guardian Name: \_\_\_\_\_ Nationality: \_\_\_\_\_

Childs Allergies: \_\_\_\_\_

Allergy Reaction: \_\_\_\_\_ Parents

family history (Tick Below)

Asthma:\_\_\_ Tuberculosis\_\_\_ Diabetes \_\_\_Epilepsy\_\_\_ Cancer \_\_\_ Diabetes\_\_\_ Nose Bleeds \_\_\_ Hypertension \_\_\_

Sinusitis \_\_\_ Rheumatic Fever \_\_\_ Sickle Cell disease \_\_\_ Stomach Problems \_\_\_ Pneumonia \_\_\_ Fever Seizures \_\_\_

Seizures \_\_\_ Autism \_\_\_ ADHD \_\_\_ Social Anxiety \_\_\_ Depression \_\_\_

Other: \_\_\_\_\_

## PHYSICIAN SECTION A.

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

1. Childs Height: \_\_\_\_\_ Childs Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

General Appearance Examination: Normal: \_\_\_\_\_ Abnormal: \_\_\_\_\_ Remarks: \_\_\_\_\_

2. Please tick if the child suffers from any listed below.

Asthma:\_\_\_ Tuberculosis\_\_\_ Diabetes \_\_\_Epilepsy\_\_\_ Cancer \_\_\_ Diabetes\_\_\_ Nose Bleeds \_\_\_ Hypertension \_\_\_ Sinusitis

\_\_\_ Rheumatic Fever \_\_\_ Sickle Cell disease \_\_\_ Stomach Problems \_\_\_ Pneumonia \_\_\_ Fever Seizures \_\_\_ Seizures \_\_\_

Autism \_\_\_ ADHD \_\_\_ Other: \_\_\_\_\_

3. Please Tick if the child had the following within 6 months:

\_\_\_ Chicken Pox \_\_\_ Whooping Cough \_\_\_ Covid19 \_\_\_ Mumps \_\_\_ Polio\_\_\_ Measles \_\_\_ None Of The Above

4. Is the child capable of participating in Physical activity? \_\_\_ Yes \_\_\_ No. If No, please state why.

## Immunization Vaccination

Immunization	1st	2nd	3rd	1st BOOSTER	2nd BOOSTER
<b>DPT</b>					
<b>Polio</b>					
<b>Hepatitis B</b>					
<b>Pneumococcal</b>					
<b>MMR</b>					
<b>Varicella</b>					
<b>Other Vaccines</b>					

### LABORATORY TEST RESULTS (Ages: 1-4/5)

Hemoglobin level (g/dl): \_\_\_\_\_

Corrective lenses? \_\_\_\_\_

### PHYSICIAN SECTION B.

5. Teeth (Ages 1 - 4): Normal: \_\_\_\_\_ Abnormal: \_\_\_\_\_

Date of last examination: \_\_\_\_\_

Remarks: \_\_\_\_\_

6. Hearing (Ages 1 - 4): Normal: \_\_\_\_\_ Abnormal: \_\_\_\_\_

Date of last examination: \_\_\_\_\_

Remarks: \_\_\_\_\_

7. Eyes (Ages 1 - 4) Normal: \_\_\_\_\_ Abnormal: \_\_\_\_\_

Date of last examination: \_\_\_\_\_

Remarks: \_\_\_\_\_

Dr. \_\_\_\_\_ Hereby certified that the child was examined by me and is found to be physically and mentally fit to attend Just Kids Academy International School.

X \_\_\_\_\_  
Physician Signature

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