**STRICTLY CONFIDENTIAL**

| |
|---|
| Please use this box to indicate any major allergy or restriction |

## Student's Health Form

This is a required form so that we have the correct medical information that we need to best care for our students.

| Family Name | First Name | Birth Date (dd/mm/yy) | Gender |
|---|---|---|---|
| | | | |

Emergency Contact - Name:
Telephone: Mobile Number:
Email:

Secondary Contact - Name:
Telephone: Mobile Number:
Email:

**Medical History:**

Has your child had any of the following? If YES, please write details below including dates, severity, and sensitivity:

| | | |
|---|---|---|
| Altitude related illness (acute mountain sickness, cerebral/pulmonary oedema) | Yes □ | No □ |
| Asthma | Yes □ | No □ |
| Anaemia | Yes □ | No □ |
| Sickle Cell Anaemia | Yes □ | No □ |
| Chicken Pox | Yes □ | No □ |
| Measles | Yes □ | No □ |
| Rubella | Yes □ | No □ |
| Mumps | Yes □ | No □ |
| Whooping Cough | Yes □ | No □ |
| Polio | Yes □ | No □ |
| Back ache, spinal injury, disk problems | Yes □ | No □ |
| Cystic Fibrosis | Yes □ | No □ |
| Diabetes | Yes □ | No □ |
| Epilepsy | Yes □ | No □ |
| Heart problems | Yes □ | No □ |
| Hepatitis (please indicate A, B or C) | Yes □ | No □ |
| Head injury, concussion, unconsciousness | Yes □ | No □ |
| Migraines | Yes □ | No □ |
| Fainting or blackouts | Yes □ | No □ |
| Mental illness (Depression, Anxiety, Phobia, Eating Disorders, Substance Abuse, other) | Yes □ | No □ |
| High Blood pressure | Yes □ | No □ |
| Lung disease | Yes □ | No □ |
| Tuberculosis | Yes □ | No □ |
| Respiratory tract infection (current or recent) | Yes □ | No □ |
| Rheumatic fever | Yes □ | No □ |
| Knee ankle or joint injury (current or unresolved) | Yes □ | No □ |
| Any other serious illness, injury, operation or condition | Yes □ | No □ |

Please provide details for all boxes marked YES. Please also give details of any other factors that may affect your child's physical, mental or emotional well-being. *(use another sheet if needed)*

**Inoculations**

Has your child been vaccinated or inoculated with any of the following? (Include dates/details as appropriate)

| | | | |
|---|---|---|---|
| BCG (anti-TB) | Date: | Yes ☐ | No ☐ |
| Gamma Globulin | Date: | Yes ☐ | No ☐ |
| HBV (Hepatitis B) | Date: | Yes ☐ | No ☐ |
| HAV (Hepatitis A) | Date: | Yes ☐ | No ☐ |
| Measles | Date: | Yes ☐ | No ☐ |
| Meningitis | Date: | Yes ☐ | No ☐ |
| Mumps | Date: | Yes ☐ | No ☐ |
| Polio | Date: | Yes ☐ | No ☐ |
| Rabies | Date: | Yes ☐ | No ☐ |
| Rubella | Date: | Yes ☐ | No ☐ |
| T.A.B. | Date: | Yes ☐ | No ☐ |
| Tetanus | Date: | Yes ☐ | No ☐ |
| Triple vaccine (DPT) | Date: | Yes ☐ | No ☐ |
| Yellow Fever | Date: | Yes ☐ | No ☐ |
| Other (please specify) | | | |

Prescription medicines required for prevention or treatment of illness or medical conditions should accompany the student as these are not always available. They should be given to the school nurse as boarders may not keep medicines.

Name of medicine supplied:

| | | | |
|---|---|---|---|
| **SIGHT**: How would you describe your child's sight? | ☐ Good | ☐ Poor | ☐ Very Weak |
| Does your child wear glasses? | | ☐ Yes | ☐ No |
| Does your child wear contact lenses? | | ☐ Yes | ☐ No |
| **HEARING:** How would you describe your child's hearing? | ☐ Good | ☐ Poor | ☐ Very Weak |
| Does your child wear a hearing aid? | | ☐ Yes | ☐ No |

| | |
|---|---|
| Give details of any hypersensitivities or allergies to drugs or food, etc. which you have knowledge of: | |
| Please indicate any particular food or dietary requirements. | |
| Give details of any medical reasons why your child may not be able to take part in organised school activities (such as swimming, sports, outdoor pursuits, horse riding, etc) or which might affect their performance in school: | |

Parent's signature: Date:

Note: All medicines (including malarial prophylactics), syringes, etc. are to be handed to the school nurse on arrival. Only the necessary minimum may be kept by the student with the school nurse's approval.

Please attach to this form any medical details which you feel it would be helpful for the School to be aware of. Should your child develop any medical condition in future which may affect their school life, we would request that you write to give us full details. The school nurse or school doctor will give your child any medical treatment or medication that they feel necessary in the case of illness or accident and you will subsequently be informed of such treatment. Please indicate on an attached sheet any points that you wish us to note.

# Health Evaluation / Physical Examination

**For new students only:**
To be completed by a medical officer before arrival at UWC East Africa. (The school does not provide this service)

| | | | |
|---|---|---|---|
| Date of Examination: | | Blood Group (A/B/AB/O, Rh+/-) | |
| Pulse: | Blood Pressure: | Height: | Weight: |
| General Appearance: | | Skin/Hair/Nails: | |
| Eyes/Vision: | | ENT / Hearing: | |
| Neck: | | Chest wall, breasts: | |
| Lungs: | | Heart: | |
| Abdomen: | | Back: | |
| Urogenitalia: | | Nervous System: | |
| Extremities: | | Mental Status: | |

Signature of Medical Officer:

Qualifications: Date: