



# HEBRON SCHOOL

OOTACAMUND, INDIA

## PRE ADMISSION MEDICAL FORM FOR STUDENTS

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Note: PLEASE USE **BLOCK** LETTERS TO COMPLETE THIS FORM AND RETURN WITH ADMISSION FORM. All questions **MUST** be answered honestly. We reserve the right to refuse admission if this form is not completed. Moreover, if a known medical condition is not disclosed, we reserve the right to ask for the student to be withdrawn even after admission.

**SURNAME:** .....

**FIRST NAMES:** .....

**DATE OF BIRTH:** .....

**SEX: MALE / FEMALE**

**SECTION A – PERSONAL HEALTH HISTORY:** Tick the ‘Yes’ column and provide the date if known or write ‘present’ to indicate if the student has any of the following currently:

	Yes		Yes		Yes
<b>Childhood diseases</b>		Hay Fever		Ingrowing toenail	
Chicken pox		<b>Chest/Respiratory</b>		<b>Neurological conditions</b>	
Diphtheria		Asthma		Epilepsy	
Measles		Chronic cough		Febrile Convulsion	
Mumps		Chest pain		Fainting	
Polio		<b>Heart/Blood Disorder</b>		Frequent headaches	
Scarlet Fever		Heart Disease		Migraine	
Whooping cough		Other heart problem		Neuritis	
<b>Other Conditions</b>		High Blood Pressure		<b>Psychological conditions</b>	
Dengue		Low Blood Pressure		Aggression	
Diabetes		Haemophilia		Alcoholism	
Hepatitis (Jaundice)		Excessive bleeding		Anxiety	
Malaria		<b>GI/GU Conditions</b>		Depression	
Glandular Fever		Appendicitis		Drug habit	
Rheumatic Fever		Bladder infection		Eating disorder	
Tuberculosis		Diarrhoea/Dysentery		Emotional health issues	
Typhoid		Gall bladder		Hysteria	
<b>Ear/Nose/Throat</b>		Gastric irritation		Insomnia	
Frequent colds		Haemorrhoids		Nightmares	
Frequent earaches		Hernia		Psychiatric treatment	
Ear discharge		Kidney infection		Sleepwalking	
Frequent nose bleeds		<b>Skin Conditions</b>		Smoking habit	
Frequent sore throat		Eczema		Temper tantrums	
Tonsillitis		Impetigo		<b>Other (please specify)</b>	
Any deafness		Frequent boils			
Tooth/Gum problems		Scabies			



**SECTION B – KNOWN MEDICAL CONDITIONS**

**Does your child have any allergies?**

Please provide details and reactions of any allergies plus any necessary treatment:

.....

Does your child suffer from any medical conditions for which they take medication to control symptoms? Eg: asthma, skin conditions, anxiety, insomnia etc.

If yes, please give details below including date diagnosed:

CONDITION	MEDICATION	DOSAGE	WHEN TAKEN	LAST REVIEWED

Has your child ever had a medical condition that involved seeing a specialist such as a Physiotherapist, Speech Therapist etc? Please provide details below:

.....  
 .....

Has your child had any of the following? Please give details:

Major Accidents:

.....  
 .....

Operations, including fractures, listing dates and any reaction to general anaesthetic:

.....  
 .....

Has your child ever been seen by an Educational-Psychologist or Psychiatrist? Please circle as appropriate.

Yes                      No

Please provide details and dates below:

.....  
 .....

**SECTION C - FAMILY HEALTH HISTORY:** Circle to indicate any occurrence of the following:

Alcoholism

Allergies

Arthritis

Asthma

Cancer

Diabetes

Emotional health issues

Epilepsy

Heart Disease

High Blood Pressure

Kidney disease

Rheumatic Fever

Tuberculosis

**SIGNATURE:** .....

**RELATIONSHIP TO THE CHILD:**..... **DATE:** .....

Pre Admission Medical Form (PAMF) updated May 2018.