Oxford Manor College

SCHOLAR'S MEDICAL INFORMATION

BIO DATA

NAME OF CHILD…….. DATE OF BIRTH……

AGE…… YEAR …….. SEX…….. RELIGION……

NATIONALITY…….. BLOOD GROUP…… GENOTYPE……..

MEDICAL HISTORY

DOES YOUR CHILD HAVE ANY KNOWN AILMENT? NO ☐ YES ☐

(TICK THE APPROPRAITE BOX)

ASTHMA ☐ SICKLE CELL DISORDER ☐ SEIZURE DISORDER ☐
OTHERS……

HAVE YOUR CHILD HAD ANY SURGERY? NO ☐ YES ☐

STATE BELOW WHAT SURGERY AND WHEN ……

……

Hospital child attends:
Name of child's doctor:
Hospital's phone number:
Doctor's phone number:

Has your child been fully immunized? NO ☐ YES ☐
(TICK THE APPROPRIATE BOX BELOW)

☐DPV/OPV ☐TRIPLE (DPT) ☐Hib ☐MMR ☐MEASLES ☐CHICKEN POX
☐OTHERS (PLEASE STATE WHAT VACCINE) ……

DATE OF NEXT IMMUNIZATION (IF ANY)……..

DOES YOUR CHILD HAVE SPECIAL NEEDS? NO ☐ YES ☐ (STATE WHAT NEEDS)……

……

DOES YOUR CHILD HAVE ANY VISION AND HEARING PROBLEMS? NO ☐ YES ☐

IF YES, SPECIFY WHICH. VISION ☐ HEARING ☐

DOES YOUR CHILD HAVE ANY ACTIVTY RESTRICTION DURING PE/RECESS? NO ☐ YES ☐

IS YOUR CHILD ADVERSELY AFFECTED BY COLD? NO ☐ YES ☐

IS YOUR CHILD CURRENTLY ON ANY ROUTINE MEDICATION? NO ☐ YES ☐

(TICK THE APPROPRIATE BOX BELOW)

MEDICATION	REASON	DOSAGE	DURATION

ALLERGIES

DOES YOUR CHILD HAVE ANY ALLERGIES? NO ☐ YES ☐

(TICK YOUR BOX BELOW)

☐ DUST ☐ PETS ☐ MITES ☐ GRASS ☐ COLD ☐ LATEX ☐ SEASONAL

☐ MEDICATION (STATE WHAT MEDICATION) ……..

☐ FOOD (STATE WHAT FOOD(S) ……..

☐ OTHERS ……

PLEASE WRITE SYMPTOM(S) THAT MANIFEST

……

……

……

HOW DOES YOUR CHILD REACT TO THE ALLERGY……

_____

WHAT REMEDY WORKS BEST FOR HIM/HER……

……..

EMERGENCY

PERSONS TO CONTACT IN EVENT OF EMERGENCY:

	NAME	**RELATIONSHIP**	**CONTACT NUMBER**
1			
2			
3			
4			

PERSONS DESIGNATED TO PICK UP THE CHILD IN CASE OF EMERGENCY:

	NAME	**RELATIONSHIP**	**CONTACT NUMBER**
1			
2			
3			

CAN A FIRST AID MEDICATION BE GIVEN TO YOUR CHILD? NO ☐ YES ☐

Parent Signature……

Date……..