



ISLK

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CONFIDENTIAL

In order to evaluate your child's health condition it is important that the doctor receives information about previous illnesses, health history accidents and vaccinations. Please complete the following form and return it to the above address along with a copy of any relevant health certificates. **This form should be submitted before the first day of school.**

Note that this information is strictly confidential and the school nurse and doctor will not inform anyone without your consent.

Surname, first name		Gender F M	Date of birth Year month day number	
Address			Phone number	
Place of birth			When did the child arrive in Sweden?	
Name and address of previous school				
Mother's name	Profession	Date of birth	Height cm	
Address (if other than the student)	Phone number home	Phone number at work / e-mail		
Father's name	Profession	Date of birth	Height cm	
Address (if other than the student)	Phone number home	Phone number at work / e-mail		

Brothers and sisters

Name	Date of birth	Name	Date of birth

Health information

Does your child have any dietary restrictions? No Yes

State what _____

Does your child take medication regularly? No Yes

What? _____ Why? _____

Does your child need medication at school? No Yes

What? _____ Why? _____

Does your child have:

Asthma	No	Yes	Diabetes	No	Yes
Hay-fever	No	Yes	Hearing impairment	No	Yes
Eczema	No	Yes	Visual impairment	No	Yes
Allergy	No	Yes	Convulsion	No	Yes
Does the child wet the bed?	No	Yes	Hepatitis	No	Yes
Recurring stomachaches	No	Yes	Recurrent headaches	No	Yes
Recurring diarrhoea	No	Yes	Any symptoms of respiratory illness	No	Yes

Health history

Has your child been treated for:

Tuberculosis	No	Yes	Malaria	No	Yes
Bowel problems	No	Yes	Urinary tract infection	No	Yes
Serious accident	No	Yes	Diabetes	No	Yes

Please give details of the above _____

Vaccinations

	Date	Date	Date	Date
DT (Diphtheria Tetanus)				
DPT (Diphtheria Tetanus Pertussis)				
Polio Drops				
Polio Injection				
MMR (Mumps, Measles, Rubella)				
PPD, Mantoux Test for TB				
BCG (TBC)				
Other				
Other				
Other				

Date: _____

Parent/Guardian: _____