Lucaya International School

P.O. Box F-44066 Freeport, Grand Bahama Island, Bahamas
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2017-2018 STUDENT HEALTH RECORD FORM

Print clearly or type form. Please complete entire form, sign & date.

Student Name: ____
(Last) *(First)* *(Middle)*

Male_____ Female____ Birth date:____________________
(Day/ Month /Year)

IMMUNIZATIONS **-** Please indicate the month and year of last immunization:

Polio		Pertussis	
Hepatitis		Tetanus	
Diphtheria		Measles	
Chicken Pox		Mumps	
Rubella		Other (please specify)	

VITAL MEDICAL INFORMATION

Operations: Please list any operations your child has had and the approximate date of the surgery.	
Previous Disorders: Please list any childhood disorders (i.e. frequent nosebleeds) from which your child has suffered.	
Chronic Disorders or other issues: Please list any other problems or chronic conditions of which the school should be made aware.	
Allergies: Does the student suffer from any allergies? (i.e. penicillin) If yes, please list. ☐ YES ☐ NO	

Does the student take any regular medication (prescription and/or non-prescription)? ☐ YES ☐ NO	Complete Name of Medication	Illness/Condition Related To	Approximate Duration of Prescription

*IMPORTANT NOTE: IF YOUR CHILD REQUIRES MEDICATION DURING SCHOOL HOURS, PLEASE COMPLETE THE "PERMISSION TO GIVE MEDICATION FORM" AVAILABLE FROM THE SCHOOL OFFICE.

GENERAL INFORMATION **-** Please list the last date the following occurred:

Physical Examination		Eye Examination	
Dental Examination		T.B. Test	
Does the student wear contact lenses or glasses?		Is the student's hearing impaired in anyway?	

______________________ ______________________ ______________

Parent or Guardian Signature *Parent/Guardian Name (Please Print)* *Date*

PHYSICIAN
I hereby confirm that the information given above is correct to the best of my knowledge.

______________________ ______________________ ______________

Doctor Name (please Print) *Doctor Signature* *Date*

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Practice Address / phone number